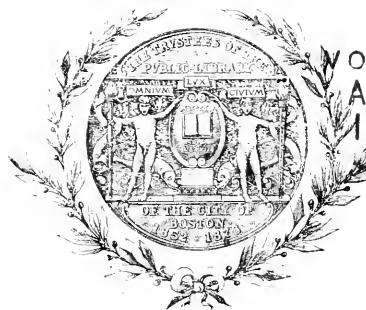


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THE CHILD

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social Security Administration
Children's Bureau



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THE CHILD

AUGUST-SEPTEMBER

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WE CAN DO SOMETHING ABOUT JUVENILE DELINQUENCY

JUVENILE DELINQUENCY is again on the increase.

In the last 3 years the number of delinquency cases handled by juvenile courts in this country has risen almost 20 percent, according to estimates based on data now in the Children's Bureau.

By 1960, *even if the delinquency rate does not increase*, law-enforcement agencies will be dealing with 50 percent more children 10 to 17 years old (the age group in which most juvenile-delinquency cases fall) than in 1950. This is because the number of youngsters of these ages will increase that much, as a result of high birth rates during and after World War II.

A million or so boys and girls are picked up by the police each year. And every time a child doesn't get the kind of help he needs at such a time, society is the loser.

Far too many of our adult jails and prisons are filled with men and women who have juvenile-delinquency records.

No one can calculate exactly the cost of maintaining all our adult criminals, but we know that it runs into millions upon millions of dollars a year.

Nor can one estimate, in any mathematical terms, the great loss to the Nation in the creative, productive, and cooperative power that these people might have contributed under other circumstances to our well-being, but we know the loss is great.

The problem of juvenile delinquency has been with us before, and many times. During World War II delinquency rose to a new peak. As a people, we have made some gains against it. But only here and there.

We have courses of training for police officers who have to deal with youthful delinquents. But only a

handful of officers have a chance to benefit from such courses.

We have to some extent stopped putting youngsters awaiting court action into jails housing adult criminals. But 50,000 to 100,000 juvenile delinquents will be held in jails this year because there is no better place to put them.

Again and again we have seen the help that well-selected, well-trained probation officers can give to juvenile-court judges. Yet more than half our counties today have no probation services to help judges weigh the problems behind a child's delinquency.

We have some training schools for juvenile delinquents which no longer put them in uniforms, crop their hair all alike, and march them this way and that. Some of our training schools have excellent diagnostic and treatment services, excellent schooling, health, recreation, and religious programs, all designed to help boys and girls in trouble to find their way out of trouble and into a responsible and satisfying role in life. But this kind of training school exists only here and there.

The time has come to pull together what we know about juvenile delinquents and their needs—what we know has worked well in helping them—and to build programs of action that will serve, not just a few, but all the youngsters who come up against the law.

This is a job that can best be done by citizens in their own communities and States. Many highly skilled and trained workers in the delinquency field are available to help.

Because citizens have a right to expect help from their Federal Government too, the Children's Bureau is stepping up its services. We have established a Juvenile Delinquency Branch in our Division of Social Services. Working closely with this new

Branch is the staff of a special Juvenile Delinquency Project, created through the generosity of private contributors.

Together, our new Branch and Project will help to bring out into the open what is known about the causes and treatment of juvenile delinquency in this country today. They will help National, State, and local citizen groups to develop programs that we hope will help delinquent boys and girls turn to activities that will increase their self-respect. Within the next several months, we will have new pamphlets and other materials that should be useful tools for such groups in organizing their own efforts in this direction.

Clearly, no such program can accomplish its end unless it is concerned with averting delinquency as well as treating it. Our special Branch and Project, therefore, will be concerned with measures to strengthen community services that make delinquency unattractive and unnecessary to youngsters.

Readers of *The Child*, associated as most of you are with services for children, can contribute greatly to this Nation-wide effort. I appeal to you to lend it your support, through the work of your present organization and through additional efforts. Your State or local committee or council for children and youth will be glad to put you in touch with other groups working against delinquency. If we can be of help to you, we invite your correspondence. We hope you will share with us an account of your activities.

Martha M. Eliot

MARTHA M. ELIOT, M.D.
Chief, Children's Bureau

TRAINING SCHOOLS AND THE FUTURE

RICHARD CLENDENEN

NINETEEN - FIFTY - TWO marks, as never before to my knowledge, a period of trial, change, and flux in training-school programs. Developments in training schools do not come about through happenstance. They grow out of problem solving. And the developments begin to add up only as they are related to the problems to be solved and the knowledge and skills available for their solution. It is impossible for me to make a comprehensive analysis of this process in a relatively brief paper. However, it seems logical to begin by listing some of the problems that seem somewhat new or pressing at this particular time.

The number of boys and girls coming to the attention of law-enforcement agencies is increasing sharply in this country. National data indicate a rise of between 6 and 8 percent in 1951 over 1950. Individual communities were harder hit, some showing a 36 percent jump in the volume of juvenile delinquency court cases. Thus far in 1952 all signs point to a still further increase.

During World War II we experienced a similar rise in the volume of juvenile delinquency. We were not surprised at this. The unsettling conditions of war have always resulted in increased delinquency, and we were able to regard the rise as a



A training-school staff member talks over a boy's misconduct with him. When such everyday problems are handled with insight, the child is helped to reshape his entire behavior.

temporary phenomenon. And at the war's end the size of the problem decreased.

But in 1949 the trend again reversed, and since that time the volume of delinquency has steadily mounted, each successive year. Obviously, many of the forces that operate during periods of tension and conflict are again at work, and we cannot assume that the situation will change soon. For unlike the 1941-45 era, the present troubled state of world affairs does not enable us to

look forward to so definite a termination of the pressures which are unsettling our national life.

In the Nation as a whole, training-school populations are mounting, too. Many schools are already caring for numbers beyond normal capacity. And this is not all. We know that in the immediate future even more children will need care. In the early forties birth rates increased sharply and have remained at relatively high levels since that time. Very soon, then, training schools that accept children as young as 10 years of age will feel the effects of that increase. By 1960 in this country we shall have 50 percent more boys and girls age 10 to 17 than we had in 1950.

How are the training schools to care for more boys and girls? There are only two possible ways for them to do this. Either existing training

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Mr. Clendenen gave this paper at a meeting of the National Association of Training Schools, held in connection with the seventy-ninth annual meeting of the National Conference of Social Work, held at Chicago.

schools must be enlarged or new facilities must be established. The sound answer in the majority of States, I believe, will not be found in providing additional housing in existing plants. This may be feasible in very small institutions, but, more often than not, training schools are already required to care for too diversified groups of children, and many schools are already too large.

Additional facilities established

There is evidence of a trend in the direction of establishing new facilities to permit better grouping of children according to their needs. California has taken the lead in this. During the last 10 years four forestry camps and three additional training schools have been established there, making a total of 10 facilities as contrasted with 3 existing a decade ago. It is only fair to point out, of course, that the population of California has increased more than 50 percent during the same period. A number of other States have established additional facilities, too. All told, between 15 and 20 new State training schools have been established in the past 10 years; some of these are giving care to Negroes, a group for which previously no such care had been provided in some communities.

Many training schools are feeling the effects of receiving a larger percentage of children with serious behavior problems. Exact data on the nature and extent of this change in training-school populations are lacking. We do not have adequate analyses of the composition of present and past populations for detailed comparisons, but many experienced administrators agree that such a shift has taken place. It is also logical to assume that a smaller proportion of children with less serious behavior problems are sent to training schools, as the social-insurance programs and the social services of schools, courts, and social agencies are expanded, thereby enabling these children, as well as children who are more dependent than delinquent, to remain in their own homes and be cared for in their own communities.

Training - school administrators have long recognized that some of the boys and girls committed to their care are too aggressive—too lacking in self-control—to handle themselves in the general program, a program geared to the needs of the more typical delinquent boy or girl. Improved community screening before commitment has left the training school with a higher concentration of the very aggressive boys and girls who need more intensive treatment in a setting providing more physical security than training schools usually are able to offer. A number of developments designed to meet this problem are under way.

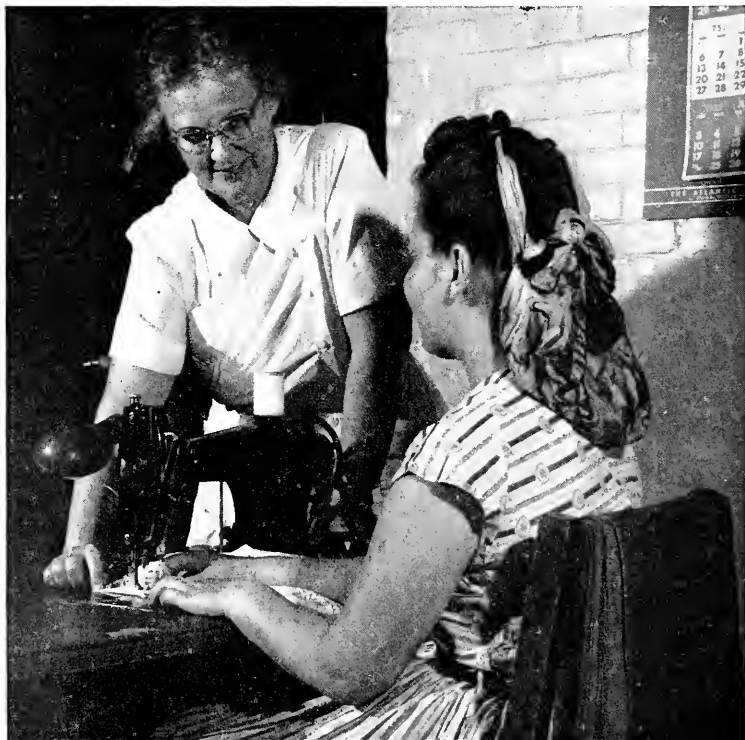
Several States are planning to follow the lead of New York and establish one or more separate facilities for the care and treatment of these so-called "unadjustable individuals." In Texas funds have already been appropriated for this purpose. A somewhat different approach to the problem is planned in California, where two combination receiving and

treatment units are to be established. Boys and girls retained in or referred to these units for treatment will be handled apart from those in reception status. Still another type of facility has been established in New Jersey, where a single study and treatment center serves both juveniles and adults, referred from a variety of sources.

Another movement aimed at the same problem, but not necessarily a substitute for this type of facility, may be seen in the establishment of security units within training schools. This is not a new idea in this field, but several additional units have been constructed within the past 2 or 3 years. These range in type from a single detention room to a ward similar to those used for housing disturbed patients in a mental hospital. This is a development that needs extremely careful and thoughtful scrutiny.

There is no ready answer to "what to do with, how to handle" the very aggressive boy or girl—and a secur-

When staff members in a training school can help a child to feel liked and wanted and important, they are likely to succeed in changing that child's attitudes toward society and self.



ity unit is not an answer in itself. I do not question that some boys and girls require temporary care in physically secure quarters. Indeed, both the aims of treatment and the protection of other people often require it. But boys or girls who are so lacking in self-control that they are temporarily unmanageable in the general training-school program are not helped to develop such control by the simple process of restricting their physical freedom to vent aggression on others and on others' rights and property. If such care is to be more than cold-storage isolation, the program within such units must be geared to meeting the needs of seriously maladjusted personalities. Adequate social, psychological, and psychiatric services are a "must." And it may be difficult to provide these services in sufficient quantities on an institution-by-institution basis. In many States it would seem more feasible to develop such a program on a State-wide basis with a single facility serving two or more training schools.

States plan to pool resources

Adjacent small States might combine resources in order to establish and maintain such a facility. Again we have evidence of some planning in this direction. In 1951 a bill was introduced in Congress to enable the States of Maine, New Hampshire, and Vermont to enter into a compact relating to the joint construction of buildings necessary to satisfy human needs in the fields of education, hospitalization, welfare, and correction. The possibility of combining resources for the establishment of certain institutional facilities also has been a topic at several interstate conferences.

Some States meet the problem of handling the very aggressive boy or girl through administrative transfer to institutions established for the care of persons convicted of crime. Yet we know that finding a young person delinquent is not the same as convicting him of a crime. Not only is such transfer of doubtful constitutionality, but it violates the spirit of

the cause for which we have long labored—namely, the development of specialized provisions and procedures for children before the law.

It is abundantly clear that the more inadequate the general training-school program is, the larger the number of children who cannot adjust within it. The ability of a boy or girl to use and benefit from the regular training-school program cannot be truly evaluated unless and until that program is reasonably adequate to do the job for which it was designed. I have visited training schools in which large security units had been constructed during periods of very inadequate program development, units little used after those programs were enriched and extended.

The need for a security unit looms largest during periods of stress and tension. And unfortunately it is at these very times that program activities become most threatened. In the face of mounting problems of control, the temptation to restrict activities is strong. Of course, some curtailment may be indicated if it seems impossible to supervise certain activities properly. But during times of tension in an institution, the need for outlets for energy and feeling is greater, not less. A material cut-back in activities will generate even more tension, which in turn will increase problems of control.

The basic job then is not new, but old; a job that training schools share with all other agencies serving children and youth. It is: How can we improve and extend present services? Obviously, as the training schools are called upon to care for more boys and girls presenting serious behavior problems, the task of providing programs adequate to meet their individual and group needs is vastly complicated. To achieve and maintain such programs requires better training for personnel than we have usually been able to provide. It requires more professional services—psychological, psychiatric, and social—than we have usually been able to command. It requires more effective, better-planned community-relations programs than we have generally

had. Above all, it requires an abundance of courage to hold the line for a treatment program in the face of increased aggressiveness in the boys and girls we serve. Happily, we are able to report progress on some of these fronts too.

Staff training is receiving wider and more intensive attention. Various new programs for on-the-job training of personnel have been established within the past 2 years. I can mention only a few here.

The National Training School for Boys, in Washington, D. C., recently appointed a full-time staff-training officer, thereby becoming the first training school, to my knowledge, to employ a person to give full time to the orientation of new personnel and the on-the-job training of all staff. With this service, the National Training School for Boys is experimenting with training methods. Recently, a cross-section of staff, about 12 in number, were released from all other duties to devote a full week to intensive group discussions of program. Interest and enthusiasm were high among participants, although it is still too early to evaluate how this experience has influenced the performance of these staff members.

In New York State the Bureau of Child Welfare of the State Department of Social Welfare has until recently assigned a staff-training specialist to work half time at the New York Training School for Boys. This specialist devoted major attention to working with the individuals responsible for the direction and supervision of houseparents and other cottage personnel.

Although still in the planning stage, the New York Training School for Boys contemplates a training and research project geared primarily to on-the-job staff training. Through the services of specialists in the fields of group work, group therapy, psychiatric casework, and clinical psychology, explorations will be made to determine what these professions have to offer in both methods and knowledge, which can be used in staff training and by staff in their respective jobs. The project team will also

include a person skilled in research who will be responsible for establishing the controls and methods necessary for evaluating results.

Somewhat more than a year ago, the California Youth Authority embarked on a carefully planned on-the-job training program, participated in by the six training schools and the four forestry camps administered by that agency.

With the help of a committee, a syllabus consisting of 12 study units was developed. Each unit represented a study outline for some aspect of the training-school job. One staff member in each facility was then selected to serve as its training officer or instructor. Prior to launching the training sessions, these persons were brought together for a week of discussion, instruction, and indoctrination.

This was followed by a 3-day meeting for going over the syllabus, identifying and defining the functions of training officers and their relationship to staff and administration, and determining the objectives of the training program. A specific amount of time was provided in each facility's budget for this on-the-job training.

Major emphasis was given to the orientation and training of new staff, but time was allotted for the training of all personnel. Group sessions utilizing a variety of methods, such as discussions led by staff members or outside persons, lectures by selected speakers, and presentation of films followed by discussions, were then arranged for regularly by the training officer in each facility.

None of the programs outlined above, nor any others with which I am acquainted, would be described by the originators as ideal or as fully meeting on-the-job staff training needs. But the fact that these, among other programs, have been started, that time and money for such staff training have been budgeted, represents a tremendous step forward. And I am convinced that we are not going to make material progress in developing staff-training programs

until we make specific provision for this function in the planning of each year's budget and work program.

One person responsible for program

Still another general observation can be made about the staff-training programs described here. In each training school, specific and continuing responsibility for carrying on the program was delegated to a selected member of the staff. Ideally, of course, this person should be especially qualified for this function. In practice, it is gratifying to observe how much can be achieved through the leadership of a person lacking such ideal qualifications, if assistance and guidance can be provided. Experience, which at this point is meager, would indicate that a training school employing a staff of substantial size could well use the services of a full-time person in the development and provision of a staff-training program. A beginning might be made in some States by employing such a person and dividing his time between two or more training schools.

I have said that the larger numbers of serious behavior problems that the training schools are being called upon to meet intensifies the need for staff training, professional services, and sound community relationships. Space will not permit me to discuss the shortage of professional personnel, nor to mention some of the interesting variations in the ways professional services are being geared into training-school programs. Neither do I have space to discuss community relations, a subject that is complicated by the uncertain, vacillating, and often punitive attitudes of the public toward the delinquent. I have also said that the job requires an abundance of courage to hold the line for a treatment program in the face of increased aggressiveness in the boys and girls we serve—aggressiveness that inevitably breaks forth at times in a manner that results in public demands to "get tough." And that kind of courageous leadership is emerging more and more.

The spread of knowledge and understanding in the training-school

field is impressive. We have long had considerable knowledge about human behavior, and progressive training schools have drawn upon this body of knowledge in program development. But we have also had large deserts into which the understanding that flows out of that knowledge has not penetrated. Gradually these deserts are diminishing.

I am referring, for example, to a fuller and more widely accepted appreciation of the importance of human relationships in the job we are trying to do. There is growing recognition that the end result of every training-school experience is determined by the network of relationships existing among those sharing it. Whereas many training schools once concentrated almost exclusively upon outward behavior, and unfortunately some still do, there is greater recognition of the importance of feelings, reactions, relationships, whatever the outward behavior.

How can we change a child's attitudes?

A better understanding of the distinction between the control of behavior and its permanent modification is developing. I do not mean to imply that the control and modification of behavior are unrelated. Rather they are most intimately related. The ways in which behavior is controlled from day to day has a strong influence upon the shaping of future conduct. And recognition that behavior grows out of the individual's attitude toward society and self has led to a wider evaluation of methods utilized in maintaining controls. Penalties that humiliate the individual, diminish his self-respect, shake his self-confidence, or confirm his feeling that the world is a harsh, unfriendly place are giving way to methods that though sometimes less effective in altering immediate behavior will over the long haul build self-respect, as well as confidence in others.

Recognition that a person's attitudes cannot be changed unless he feels liked and wanted and important has led to wider efforts to make boys

(Continued on page 14)

TOWARD BETTER AND SAFER CAMPING

A State Welfare Department Surveys Children's Camps

MARTIN GULA

THIS SUMMER more than three million boys and girls have been away from home for weeks, or even months, camping in the woods, at a lakeside, or in some other natural setting. Some parents have paid several hundred dollars in fees for private camps; others have sent their children to less expensive camps, operated by nonprofit organizations. All the parents expect the camp to safeguard their children's life and health. All hope that their children will have an enjoyable time that is also a wholesome, constructive experience.

Many camps fulfill these parents' expectations. A camp that is admitted to membership in the American Camping Association, for example, is recognized as a camp that lives up to the high standards set by the Association. In the same way, the Boy Scouts and the Girl Scouts, the YMCA and the YWCA, the Boys' Clubs of America, and some other national groups hold their member camps to high standards.

Large numbers of camps, however, are not accredited by any organization. When a mother and father send Joe or Susie to a camp that they have heard about through an advertisement, or from a neighbor, what assurance have they that the camp will be suitable for the child? Will the workers in charge be mature, responsible persons, who understand children and like them, who know

how much activity boys and girls of different ages can undertake, and who will not subject a child to tiring competition? Will safety provisions be adequate? Will a doctor be available if the child falls ill? How about emergency hospitalization?

Many parents, and some social agencies too, assume that camps are supervised by State authorities, as many schools are, and as children's institutions are. It is true that most States, through their public-health laws and regulations, set minimum sanitary requirements, such as those concerning sewer facilities, garbage disposal, and water supply. But few State laws or regulations pay attention to the qualifications of the director and his staff—the persons responsible for safeguarding the children's lives, their health, and their well-being, while they are away from home.

Not many States, for example, require that a registered nurse be on the staff, to watch for signs of illness in the children and to judge when a

doctor is needed. Few require camps to make sure that a doctor can be reached in an emergency. And although swimming and boating are a prominent feature of the activities in most camps, only a handful of States include a requirement that some one employed by the camp be able to administer artificial respiration.

Yet even if all the States had laws or regulations requiring camps to meet high standards, enforcing these requirements would take more staff than many State governments have been able to provide. Up to now, few States have been able even to assess the extent of camping within their borders, much less to provide enough staff to supervise the camps adequately.

But in spite of the difficulties, some States are trying to fulfill their responsibility for guarding the welfare of the youngsters that every summer throng to camp. Among these States is California.

The California State Department of Social Welfare is responsible by

"Having wonderful time." Their parents hope that it will also be a safe and healthful time.



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law for protecting children under 16 years of age in "the absence of their parents," and its Division of Child Welfare fulfills this responsibility through inspecting and licensing a variety of facilities for child care.

The Department has for many years recognized its responsibility for inspecting and licensing summer camps for children under 16, but it has never had enough staff for this purpose. However, it has been able to take action on any serious complaint about a camp. And it has inspected and licensed a small number of camps that requested this service. Also it has worked with the help of the American Camping Association toward developing tentative standards for protecting the health and safety of child campers in the State.

A long step forward was taken toward fulfilling the Department's responsibility for protecting children in camps through licensing, when the State legislature provided, in the Department's budget for 1951-52, the equivalent of two full-time positions, specifically for work with camps. With this provision the Department planned the following activities:

1. A survey of camps—locating and identifying camps to determine the number and type of camps and the number of children served and to collect information on camping practices.

2. Inspection and licensing of as many camps as possible on a cross-section sampling basis as to types and location.

3. Identification of any problem areas, and evaluation of the practical problems of licensing.

4. Continuation of the process of development of standards to protect the basic health and safety of campers and to promote good camping practice."

In its work toward these goals the Department enlisted the help of a committee representing the organizations in the State with major leadership in the field of children's camping. These included the five California sections of the American Camping Association; the Pacific Camping Federation; the Northern

and Southern California Private Camp Directors' Associations; the national youth-serving organizations—Boy Scouts, Girl Scouts, Camp Fire Girls, YMCA, YWCA, Boys' Clubs of America, and Salvation Army; governmental agencies, such as the State Fire Marshal, the State Department of Public Health, the State Recreation Commission, the State Department of Education, the State Division of Beaches and Parks; and the United States Forest Service.

Committee's work appreciated

This committee gave valuable service in locating and identifying camps, in interpreting the Department's program to individual camps, and in guiding the Department in methods of approaching the problem as a whole.

The first step in the survey was to collect the names and addresses of as many camps as possible, even though it was clear that a large number of these would have to be removed from the list, for some would be duplicates, some would no longer be in operation, and many would prove either to be not "established camps," by administrative definition, or to be outside the jurisdiction of the Department of Social Welfare. (Camps maintained by public schools or other public agencies, camps for the handicapped, week-end or day camps, family camps, and camps for boys and girls over 16 are not the responsibility of the Department of Social Welfare.)

The members of the survey committee provided the names of a large number of camps affiliated with their organizations. Other sources of information were county health and welfare departments and churches and church organizations. Then there were local camp organizations, chambers of commerce, directories published by clothing and camp-supply stores, welfare councils, local park and recreation commissions, automobile club lists, and so forth.

About 900 names of camps were obtained, and a questionnaire, accompanied by an explanatory letter and a copy of the tentative camp stand-

ards, was sent to each. The letter told the camp that the State Department of Social Welfare planned to inspect and license a cross-section of camps, and that for this reason the questionnaire had been designed to serve also as an application for license. The camps were assured that all information would be confidential and that no data on individual camps would be published.

The letter went on to say:

"In filing the completed questionnaire, you will have fulfilled your obligation under the law to apply for a license, even though the Department is unable to complete a licensing study of your camp this summer. In this year's work with camps the Department will select a sample of all types of camps in the major camping areas of the State.

"If your camp is selected for licensing (no fee involved), an appointment for a visit, at your convenience, will be arranged. If you would like to be included in the sample, please let us know.

"In licensing camps the Department will make every effort to individualize camps. There will be no attempt to fit camps to a single preconceived idea of a "good camp." The items on the questionnaire are not specifically related to licensing; "no" answers will not necessarily mean that a license could not be issued. You will note that the standards for licensing, which are enclosed, are tentative for this year at least, and that suggestions for changes will be welcomed."

Among the items on the questionnaire were:

What is the minimum age for counselors?

Has the camp been inspected by fire-safety officials? By health officials?

Is a qualified water-safety instructor on the staff?

Is a physician on the staff, or on call and accessible?

Is a registered nurse on the staff?

Is a precamp medical examination required for campers? For staff?

Is the camp accessible by a good road?

Have arrangements been made for emergency hospitalization?

Of the camps that were sent copies of the questionnaire, 368, in 43 of the State's 58 counties, returned completed questionnaires in time for tabulating. These camps had a seasonal capacity of nearly 166,000 campers (capacity at one time multiplied by number of sessions). Non-profit groups operated more than three-fourths of the camps; 80 camps were privately operated. Most of the camps served children in the 8-16 group; 22 accepted children of pre-school age and 92 served 6- and 7-year-olds. The large majority of the campers were between 8 and 12 years old.

Quality of personnel stressed

No attempt was made to evaluate individual camp programs on the basis of the questionnaires. However, the Department, in its report, classifies the camps according to their major program emphasis. Some camps went in for outdoor primitive camping; others had a major interest in athletics, team sports, and games; others were set up for the purpose of religious education; still others were planned to serve underprivileged children (a few of these camps were interested in treating children with behavior disturbances). The Department does not intend to suggest that any one of these types of camp programs is more desirable than another, but rather to point to the necessity for wider knowledge, understanding, and experience in persons who evaluate such programs.

The most important factor in camping, as in any other child-welfare program, says the report, is the quality of the personnel. There is general recognition that camp counselors with responsibility for supervision of living-groups should be mature, responsible persons, at least 19 years of age. It was, therefore, a matter for serious concern that more than half the camps had counselors under the age of 19.

The Department selected a cross-section of the camps to be visited by its staff. With the funds allotted for

the 1951 work with camps a camp consultant was employed for 6 months and six social-welfare agents for 3 months each. In the course of the summer the six agents visited 123 camps of various types. These were in 32 counties, representing all the major camping areas of the State.

Of the 123 camps visited, the Department issued licenses to 66 (53 percent). In practically all of the 66, it was necessary for the camp to make changes before it could be licensed.

Another 26 camps would probably have been licensed were it not for delay in receiving their fire-safety or sanitary clearances. The Department workers visited some of the camps late in the season, and frequently a camp would be closed before local fire or health officials could inspect it. A serious factor in lack of inspection was that some counties did not have complete fire- and health-inspection services.

The remaining 28 camps could not be licensed, either because these camps did not provide basic minimum protection of the children or because it was not possible in a brief visit to obtain sufficient information as to whether minimum standards were met.

Major problems preventing camps from being licensed were in the following categories:

1. Fire safety. Major changes or improvements were needed to bring the camp to minimum standards of fire safety.

2. Sanitation. Correction of hazardous conditions needed before sanitary conditions would be satisfactory—sewage disposal, water supply, and so forth.

3. Personnel. Counselor staff inadequate in number or questionable as to age, training, or experience.

4. Medical-care program. Pre-camp examinations not required for campers, or for staff, or for both; inadequate provision for health supervision or emergency medical care, or both.

5. General administrative organization. Responsibility for care and supervision of campers not clearly placed; general organization and administrative lines unclear.

In general the response to the licensing program was good. Most camps willingly made changes or planned to make them in the following season in order to provide basic minimum safety.

The Department's experience in visiting camps showed that a worker could be expected to visit two camps a week. Half a day in each camp is needed in order to gather sufficient information to evaluate operation

(Continued on page 14)

Under guidance of mature, understanding staff, children can gain rich experience in camp.



A VISITOR'S VIEW OF CHILD WELFARE IN VIENNA

H. TED and BUNNY RUBIN

AUSTRIA HAS ALWAYS looked to Vienna as the stimulus to its progress in social welfare, and much of the western world in the past has done the same. For in Vienna dynamic psychology had its genesis, and the soil out of which it grew was the same as that out of which arose Vienna's advanced social-welfare structure.

But World War II left Vienna with many bombed homes, schools, and welfare institutions; many health problems; physically handicapped citizens; parentless children; and the uncountable damage resulting from widespread injurious experiences. And only now is Vienna beginning to shake off the deadening effects of the Hitler *Anschluss* and the devastation of war.

Austria's social-welfare program, like that of most European nations, is largely a public one. In the immediate postwar period, a considerable part of Vienna's social-welfare budget had to be allocated for reconstruction and rehabilitation, and could not be used for new developments needed in this field. The general poverty of the country has seriously restricted the carrying through of plans for improvements.

It has also severely limited family incomes. And this in turn has resulted in a high proportion of working mothers; in consequence, the city has to provide day care for a large number of children.

Provision for care for preschool children includes day nurseries for children from 6 weeks of age to the second birthday; also day-care centers for children 3 to 4 years of age and for 5- and 6-year-olds. For school-age children the city provides centers for after-school study and recreation. Vienna's schools, which are open 6 days each week, close very early in

the afternoon, and this necessitates many such centers.

The American type of kindergarten, with its primary emphasis on education rather than on social welfare, is nonexistent in Vienna. Enrollment in day-care centers and kindergartens is restricted to children whose mothers work. Although many more are eligible, at present about one Viennese child out of seven participates in a preschool group experience.

Newer ideas slow of acceptance

Another major factor that has shaped Vienna's present social-welfare program, to a degree difficult for the outsider to realize, has been the devotion to past tradition of many officials and of a tremendous part of the people as a whole. Perhaps it is understandable in the current period of impoverishment that the Viennese people look back to their once golden age of leadership. Still, the more progressive social-welfare leaders feel hindered by this glorification of the past and the accompanying resistance to adapting to changed conditions.

Examples of this are the slow and difficult struggles in the municipal *Jugendamt*, or children's office, to shift the emphasis from the chiefly physical factors in the child's development to the social and psychological ones, and to alter accordingly the requirements for district directors. The newer movement is aiming to require directors to have been trained in working with the whole child and individualizing him, instead of, as at present, requiring them either to have a legal background or to have had training that stresses the child's physical development.

In each of the various districts a *Jugendamt* forms the core of Vienna's child-welfare program, and serves children until the end of their eighteenth year. It is often located in the same building as the district tuberculosis office, the health office, the well-baby clinic, the marriage bureau, the vital-statistics bureau, and the office of guardians for children born out of wedlock.

Through the *Jugendamt* the city furnishes every baby with a complete layette. Behind this program is an effort to control congenital syphilis, since each expectant mother must undergo a Wassermann test before the fourth month of pregnancy in order to obtain the layette. The *Jugendamt* social worker arranges for this test and also visits the home after the baby is born.

In Austria the State assumes the guardianship of every child born out of wedlock, and a so-called statutory guardian in the *Jugendamt* handles questions such as establishment of paternity and arrangement for the financial allotment required of the father. The social aspects of illegitimate birth are dealt with by the regular *Jugendamt* social worker.

In addition, this social worker regularly serves as doctor's assistant in one or more well-baby clinics and arranges for summer holiday camps for school-age children. She also carries 170 or more cases, including family problems that involve children, behavior problems of children, and referrals to various child-care facilities.

H. TED RUBIN received his master's degree from the School of Applied Social Sciences, Western Reserve University, and he is now a caseworker with the Illinois Children's Home and Aid Society, Chicago. BUNNY R. RUBIN received her master's degree from Western Reserve University in Speech and Hearing Therapy. She is an instructor at the Speech and Hearing Rehabilitation Clinic, University of Illinois Medical School, Chicago.

In addition to studying child welfare in Vienna, Mr. and Mrs. Rubin have surveyed child-welfare facilities in several other European countries and have taught at a training center for institutional personnel in Geneva.

ties. She makes pre-licensing studies of foster homes and supervises children in these homes. She also makes weekly visits to two or three schools or day-care centers, where she advises teachers and works directly with some children. Besides all this, she writes her own short case records without secretarial assistance.

How much help can a social worker give individual children when she has such wide responsibilities? Without the benefit of the type of supervision that stimulates continuous professional growth, without much knowledge of how to apply psychological principles to social work, and without much time because of her many duties, her work must be largely limited to efforts to improve the children's environment.

"Viennese people consider social service a public duty provided as a matter of right to all; they feel no diminished status in seeking such help, and use facilities more easily than do most people in the United States," explains Dr. Anton Tesarek, city director of child welfare. "Vienna has a highly specialized child-welfare organization without highly trained social workers. United States caseworkers have done wonderfully in a comparatively few cases." Dr. Tesarek continues. "In Vienna specialization has been neglected to handle many thousands of cases."

A *Jugendamt* social worker, in her work with problems concerning children, may seek guidance from her senior social worker, and in cases of parental neglect the juvenile court

home. *Erziehungsberater* may best be translated as "counselor on children's total development." Aichhorn introduced these counselors into the *Jugendamt* and trained the first of them in the 1920's.

After the staff decision to place a child away from his home, the social worker takes him to Vienna's central 212-bed *Kinderübernahmestelle*, literally the "children's-taking-over-center." Here the child receives physical and psychological examinations; and some social history is obtained. After a stay of several weeks or months, he is placed in a foster home or an institution.

Parents unable to pay for foster care

Approximately 1,400 children are in foster homes supervised by the city of Vienna. Since by law the *Jugendamt* is responsible for supervising foster homes, no private Viennese social agency can place children in such homes. Low incomes prevent parents from contributing a meaningful percentage toward reimbursing the city for foster care of their children.

Physical destruction resulting from the war has strongly contributed to the foster-home shortage. Twenty-one percent of all Viennese dwelling units were damaged, and only a handful of new housing has been completed since this took place.

The money allotment for foster-home care has increased more than 100 percent since the end of the war, and this has helped to increase the number of homes. Viennese foster mothers now receive the equivalent of \$7.50 to \$8 per month per child; this is in line with the average father's monthly income of \$28 to \$30. The cost of living is far lower than in the United States, but in addition to food expenditures, the foster-home allotment must cover recreation, allowance, dry cleaning, and shoe repairs. Foster homes in areas beyond the city limits receive the equivalent of \$4.50 to \$6 per month per child. Nearly half the boarded-out children live in foster homes in the provinces outside Vienna.

(To be continued in October issue)



Children of Vienna's working mothers attend day-care centers operated by the municipality.

A step forward, however, has been taken by the city-operated school of social work, the most advanced of Austrian social-work schools, which has initiated a long-range program to develop the teaching and practice of casework and to encourage the introduction of trained supervision. Like many other European schools of social work, the Vienna school requires no previous university education for admission.

may actually award partial or total custody of the child to this senior worker. The latter then guides the regular worker in planning for and in supervising the child.

For help with her most difficult cases, the social worker consults with the office's *Erziehungsberater*, who may herself advise the child and the family, or may recommend outside psychological treatment, or may suggest placing the child away from his

FOR BETTER CHILD HEALTH

Pediatricians Exchange Views on Ways to Solve Children's Health Problems

HOW SUCCESSFULLY an adolescent solves his life problems depends partly on how well he solved the same types of problems when he encountered them in earlier childhood, said Dr. Reginald S. Lourie, at the Eastern Area meeting of the American Academy of Pediatrics, held in Washington, May 22-23, 1952.

Dr. Lourie, who is Director of the Department of Psychiatry, Children's Hospital, Washington, D. C., cited examples of the types of difficulties that a child meets again and again in his life. Some of these, Dr. Lourie said, grow out of the youngster's close relationships with other people; some are related to the need for his obeying rules; others are concerned with his learning orderliness and cleanliness. Then there are problems concerning his concepts of his own body and of sex.

When the adolescent gets another chance at solving such problems, went on Dr. Lourie, he may be able to correct distortions in his ideas that faulty training or environmental situations had previously created. And in adolescence the child deals with the old problems in new ways—with different perspectives and more energy—ways that can make him and the people around him uncomfortable.

Dr. Leona Baumgartner, New York City's Assistant Commissioner of Health, and formerly Associate Chief of the Children's Bureau, stressed the need for integrated and concentrated research on the underlying causes of mortality and morbidity among infants in the dangerous period before birth and just afterward. Dr. Baumgartner advocated development of one or more institutes where continuing studies of such mortality and morbidity can be made through research by workers in many fields—by the embryologist,

the chemist, the physiologist, the pediatrician, the obstetrician, the physicist, the sociologist, the statistician—in fact, by every kind of research worker who has something to contribute toward solving this problem.

What one medical ward is doing

Can we decrease the emotional impact of hospitalization on a child and his parents? Discussing this question, Dr. Dane G. Prugh of the Children's Medical Center, Boston, described an experiment in one medical ward. In this experiment professional workers in a number of fields are joining to lessen children's disturbing reactions to illness and hospitalization.

One step in this direction is to reduce the amount of separation between child and parents, Dr. Prugh reminded his audience. And so the ward's welcome to the parents begins when the child is first brought to the hospital. At this time the mother and father may accompany the child to the ward, where they meet and talk with the staff members. Again, they are encouraged to visit their child every day. If they cannot come at the regular visiting hours, arrangements are made for them to come at times more convenient for them. They may also help to care for their youngster. They may feed him, or read him to sleep, or, if they wish, just sit by his bed and hold his hand.

Many people concerned with hospital management have long thought that children cry more if their parents visit them frequently than if the visits are far apart, said Dr. Prugh. But when the parents come every day, he said, the children soon realize that the separation will be short. And they cry less frantically and less frequently than do children who are visited only once a week.

In the experimental group, special attention is paid to the individual needs of every child, Dr. Prugh said. For example, a play supervisor offers various kinds of activities to meet the emotional needs of different children. Although more than one nurse may give care to a child from time to time, an effort is made to assign one nurse to be in particular charge of him. Dr. Prugh made it clear that this is done especially for a young child or one having difficulty in adjusting.

The adjustment of different children is discussed at a weekly staff conference. At this conference, which is directed by a pediatrician with psychiatric training, various professional workers contribute ideas from their own points of view. Such a conference may include the ward physician, the head nurse, the play supervisor, the occupational therapist, the medical social worker, the dietitian, the psychologist, and frequently a public-health nurse.

Efforts are made to keep from scheduling injections or other unpleasant medical procedures near the child's time for play, or a meal, or a nap.

Flexible methods v. conventional ones

Dr. Prugh told of a research study that was made to compare the adjustment of the children treated by these flexible methods with that of the same number of children cared for by traditional methods. Children in the latter group saw their parents only once a week, for an hour, and in other ways the conditions were similar to those in most hospitals.

Dr. Prugh said that the children were studied both while they were still in the hospital and after they were taken home, and their reaction to their hospital stay were noted.

All the children, he said, showed some adverse reactions. In both

groups, the most severe reactions were in the children 3 years of age and younger. In children 4 to 6 years old severe reactions were less common, and in children over 6 they were few.

After returning home most of the children behaved much as they did before going to the hospital. A number, however, in both groups showed significant behavior disturbances soon after being discharged that they had not shown before they were hospitalized. More of those in the conventionally treated group showed this temporary maladjustment than of those more flexibly treated.

Dr. Prugh said that in every age group the children who had received the specially planned individual treatment, including daily visits from their parents, showed fewer and less severe reactions than did those treated by conventional methods.

Narcotics users need medical aid

Dr. Harold Jacobziner, Director of New York City's Bureau of Child Health, urged special institutions for teen-age narcotics users. He based his recommendation on studies of more than 150 high-school students who, when given medical examinations during the 1950-51 school year, were discovered to be users of narcotics.

Most of these boys and girls were not true addicts, Dr. Jacobziner reported. They could be weaned away

from use of narcotics, he said, by a 4- to 5-month course in a special institution.

Dr. Jacobziner also urged that teen-age narcotics users not be treated as offenders against the laws, but as diseased persons who need medical aid. Treatment, he continued, should include not only withdrawal of the drug but mental, emotional, and social rehabilitation.

Twenty-five scientific exhibits had been set up in connection with the meeting. Among these were exhibits on Dental services (Children's Hospital, Washington, D. C.); Evaluation and handling of the infant and preschool child with impaired hearing (Harriet Lane Home, Johns Hopkins University Hospital, Baltimore); Psychological evaluation of physically handicapped children (Bureau of Maternal and Child Welfare, Health Department of the District of Columbia); Unsolved problems in fetal and infant mortality (Children's Bureau, Federal Security Agency.)

The Children's Bureau exhibit highlighted the hazards to babies during the last few weeks of gestation and the first few weeks of life. It listed these facts on deaths of unborn and of newborn babies:

In the United States in 1949—

1. Unborn babies who died just before birth reached a total of 48,000. Not all of these were full term, but all were at least "7-month babies."

2. Over 37,000 babies died before they were a day old. These deaths represent a third of all deaths during the first year.

3. Deaths in the first week of life amounted to over 65,000—58 percent of all the deaths of babies less than a year old. (This figure includes, of course, the 37,000 who died before they were a day old.) Of the 65,000 babies that died during their first week nearly 40,000 were prematurely born.

Deaths in the first week still high

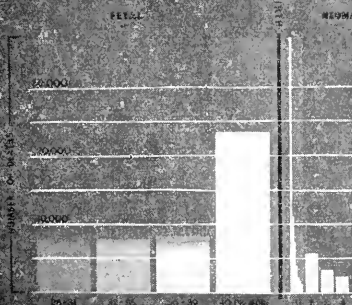
The exhibit compared infant deaths in 1948 with those in 1915, when improved birth registration first permitted study of trends in infant mortality. During those 34 years the death rate for babies in their first year of life was reduced by more than two-thirds, but for those in their first week the decrease was only one-third.

Dr. Alice D. Chenoweth, pediatric consultant on the staff of the Children's Bureau, discussed the implications of the exhibit with some of the pediatricians attending the meeting. Now that maternal mortality has been so greatly reduced, she said, and also the deaths of infants from the second month of life to the end of the first year, both pediatricians and obstetricians are focusing their attention on the babies that die before birth or soon afterward.

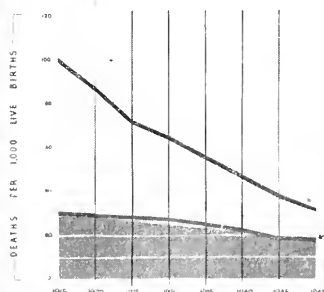
UNSOLVED PROBLEMS

IN FETAL AND INFANT MORTALITY

risks are greatest around birth

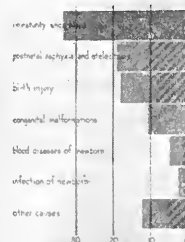


little gain has been made in reducing mortality in the first week of life



over 60% of the deaths in the first week are in prematures

causes of death



TRAINING SCHOOLS

(Continued from page 6)

and girls in training schools feel the respect and dignity fundamental to the mental health of each of us. Carefully planned reception and orientation procedures, student participation in program planning—these are not frills but important ingredients in treatment. Decent clothing, palatable and attractive food, pleasant surroundings, courteous handling—these are not privileges but the rights of every American child, and these, too, are essentials in a treatment program.

In my work with the Children's Bureau I visit training schools in every part of the country. And in the course of these visits I am impressed again and again by the fact that the training-school administrator occupies a trying and lonely position. He must reconcile the demands of treatment with the need to protect children, program, and public. Failure to provide adequate protection will quickly result in public criticism. At the same time, colleagues in closely related professions are frequently intolerant of any restrictions placed upon the children under care. While subjected to these conflicting demands, the administrator must develop a treatment program, which means achieving and maintaining a progressive but realistic focus for himself and staff.

Yet in a broader sense, his is not a solitary endeavor. Others are engaged in this same hard task. For the program he seeks to develop is directed toward resolving human conflict, improving human relationships—and this is the concern of all of us. The wellsprings of juvenile delinquency—neglect, poverty, fear, hate, cultural conflicts, ignorance—these are also the wellsprings of all human conflict. And whether we work to improve training-school programs or the United Nations, we are applying ourselves to the task of helping people to find a constructive and satisfying way of life in a society of free men.

Reprints in about 6 weeks

CAMPING

(Continued from page 9)

properly. Travel to camps requires a great deal of time because many of them are located many miles from the nearest major highway.

The Department's report of the survey points to the serious need of adequate State staffing if protection of children in camp is to be achieved. The report says:

"While the 1951 licensing experience cannot be considered conclusive as to the number of camps one field worker can license, it did provide the following general conclusions, on which future plans for licensing would need to be based:

"Staff must be available on a year-round basis and not during the summer months only. The most constructive work in bringing about improvements in camps can be done only during the noncamping season. Changes in staff, buildings, sanitary facilities, and so forth cannot be made while children are at camp.

"Most camps begin to plan for the summer during January and February. Counselor recruitment is begun in February and staffs are usually complete by April or May. Camp repairs and improvement are made in the spring and sometimes during the winter, if weather permits.

"It is essential to have staff in the summer to visit and evaluate camps; in the fall to follow-up with camps on the results of the summer visiting; in the winter and spring to discuss preliminary planning for next season's operations.

"Fire and sanitary inspections should be requested by the first of April at the latest, to allow time for any needed changes. Ideally, camps should be licensed before the season starts and visits during the season made as a follow-up on discussed plans and as the basis for next season's license.

"As more experience is gained and more camps licensed, it can be expected that renewals of licenses will require less time, but it can be expected that there will be considerable

turnover of cases with the development of new camps, which will require more time.

"Sufficient staff must be available to act promptly on serious complaint situations, without neglecting the total caseload of camps.

The foregoing information on California is given in a report of the 1951 survey, published in February 1951 by the State Department of Social Welfare, entitled "Camps for Children in California."

During the present year, the Department has continued to work with its camp advisory committee, which has been expanded to include representatives of additional groups.

A subcommittee, appointed to consider sound, practical requirements covering all aspects of fire safety in camps, has developed a booklet, "Guides to Fire Safety in Camps for Children in California," and copies have been sent to all camps. Another subcommittee is considering sanitation and the whole area of health protection. Plans have been worked out with the State Department of Public Health and the Conference of Local Health Officers, under which sanitation inspection services will be available to every camp.

Licensing activity, still on a limited scale, is continuing, with major emphasis on private camps. Cooperative efforts toward stimulating the camps to meet minimum standards are continuing with such groups as the American Camping Association and the national youth-serving agencies.

California's State Department of Social Welfare is hopeful that its efforts will bring about a sound practical program in the State, leading to adequate protection of children in camps.

A number of other progressive States also are working to improve camping programs for their children. These efforts are becoming more and more significant in view of the rising number of children in the United States, for by the end of the present decade probably as many as 4,000,000 youngsters will be going to camp each summer.

IN THE NEWS

Education for social work. After several years devoted to a study of methods of improving social-work education, the National Council on Social Work Education, reconstituted as the Council on Social Work Education, began operation July 1 with a new constitution and by-laws.

The Council is now governed by a delegate body of 78 members. Thirty of these are representatives of educational institutions—graduate schools of social work (20) and undergraduate departments (10) offering programs with social-work content introductory to professional social work. Eighteen represent national professional social-work organizations. Another 18 represent national agencies employing social workers (9 public agencies and 9 private). The other 12 delegates are members-at-large, representing higher education—especially departments of the social sciences—disciplines related to social work, and the general public.

The work is carried on by four commissions: A commission on accreditation; a commission on program, planning and services, and publications; a commission on research; and a commission on schools and departments of social work.

The Council will assume the functions that have been carried on by the American Association of Schools of Social Work and the National Association of Schools of Social Work.

FOR YOUR BOOKSHELF

A HEALTHY PERSONALITY FOR YOUR CHILD. Federal Security Agency, Social Security Administration, Children's Bureau. CB Pub. No. 337. Washington, 1952. 23 pp. For sale at 15 cents by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

Nobody is completely certain about the way personality gains health and strength. But many people—psychologists and psychiatrists, anthropologists and sociologists, physiologists and geneticists—have been studying children for many years.

They have some practical ideas about what brings good results in building healthy personalities. Some of the conclusions they have arrived at are given in this pamphlet, which was written by James L. Hymes, Jr., Ed.D., Professor of Education, George Peabody College for Teachers, Nashville, Tenn.

Dr. Hymes based his manuscript largely on material submitted to the Fact Finding Committee of the Mid-century White House Conference by Dr. Erik H. Erikson and incorporated in the report of this committee, entitled "For Every Child a Healthy Personality," which is usually referred to as the "Fact-Finding Digest."

For the use of parents' groups interested in exploring problems of emotional growth in children, a discussion aid based on this pamphlet has also been published. See the notice below.

DISCUSSION AID FOR "A HEALTHY PERSONALITY FOR YOUR CHILD." Federal Security Agency, Social Security Administration, Children's Bureau. CE Pub. No. 338. Washington, 1952. 16 pp. For sale at 10 cents by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

Mrs. Marion L. Faegre, Consultant in Parent Education, Children's Bureau, and Dr. Hymes, the author of "A Healthy Personality for Your Child," collaborated in preparing this discussion aid for use by parents' groups.

The bulletin includes suggestions on subjects for discussion and on methods of conducting group meetings. It lists some useful material—pamphlets, books, and films.

CALENDAR

Aug. 25-28. American Legion. Thirty-fourth annual national convention. New York, N. Y.

Aug. 26-28. American Political Science Association. Forty-eighth annual meeting. Buffalo, N. Y.

Aug. 27-29. Southwest Regional Conference on Migrant Labor. (Needs of children and youth.) University of New Mexico. Albuquerque, N. Mex.

Aug. 31-Sept. 2. National Council on Family Relations. New Brunswick, N. J.

Sept. 1-5. National Urban League. Annual conference. Cleveland, Ohio.

Sept. 1-6. American Psychological Association. Sixtieth annual meeting. Washington, D. C.

Sept. 1-30. Sight Saving Month. Information from National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Sept. 3-5. American Sociological Society. Forty-seventh annual meeting. Atlantic City, N. J.

Sept. 6-7. American Society of Dentistry for Children. Silver anniversary meeting. St. Louis, Mo.

Sept. 8-11. American Dental Association. Ninety-third annual meeting. St. Louis, Mo.

Sept. 11-13. National Legal Aid Conference. Thirtieth annual conference. San Francisco, Calif.

Sept. 11-16. National Conference of Catholic Charities. Thirty-eighth annual meeting. Cleveland, Ohio.

Sept. 15-18. American Hospital Association. Fifty-fourth annual convention. Philadelphia, Pa.

Sept. 17. Citizenship Day.

Sept. 17-19. National Conference on Citizenship. Seventh annual meeting. Washington, D. C.

Sept. 28-Oct. 4. Christian Education Week. Twenty-second annual observance. Sponsored by the National Council of the Churches of Christ, Division of Christian Education, 79 East Adams Street, Chicago 3, Ill.

Sept. 29-Oct. 3. National Recreation Association. Thirty-fourth National Recreation Congress. Seattle, Wash.

Regional conferences, American Public Welfare Association:

Sept. 2-4. West Coast region. Victoria, B.C., Canada.

Oct. 9-11. Northeast region. Philadelphia, Pa.

Oct. 23-25. Southeast region. Charleston, W. Va.

Regional conference, Child Welfare League of America:

Sept. 25-27. Midwest region. Des Moines, Iowa.

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CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

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THE CHILD

OCTOBER 1952



UNITED NATIONS DAY, 1952

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A Proclamation

WHEREAS the founding of the United Nations has given the people of the world an organization through which nations may resolve their differences without resort to war and has made possible greater international cooperation in the economic, political, and cultural fields; and

WHEREAS the United Nations continues to be the only existing international organ which offers mankind a hope for ultimate world peace; and

WHEREAS the realization by citizens of other nations that the overwhelming majority of Americans support the United Nations and its great purposes would help to speed the day when there will in fact be peace on earth, good will toward men; and

WHEREAS the General Assembly of the United Nations has declared that October 24, the anniversary of the entry into force of the United Nations Charter, shall be dedicated each year to the dissemination of information concerning the aims and accomplishments of the United Nations:

NOW, THEREFORE, I, HARRY S. TRUMAN, President of the United States of America, do hereby urge the citizens of this Nation to observe Friday, October 24, 1952, as United Nations Day by sending greetings to friends, relatives, and associates in other countries which are members of the United Nations, and by expressing their confidence in the United Nations, their friendship for other peoples, and their faith in the ultimate demonstration throughout the world of the brotherhood of man.

I also call upon the officials of the Federal, State, and local Governments, the National Citizens' Committee for United Nations Day, representatives of civic, educational, and religious organizations, agencies of the press, radio, television, motion pictures, and other communications media, and all citizens to cooperate in appropriate observance of this day throughout our country.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this seventeenth day of July in the year of our Lord nineteen hundred and fifty-two, and of the Independence of the United States of America the one hundred and seventy-seventh.



By the President:

Dean Acheson

Secretary of State

Harry Truman

FURTHERING INDIVIDUAL WELL-BEING THROUGH SOCIAL WELFARE

MARTHA M. ELIOT, M.D.

Chief, Children's Bureau

TO THOSE of us who spend our days and years in the broad field of social welfare, it seems unnecessary to labor the point that the welfare of our society as a whole and individual well-being are indivisible, that our culture has been built around the individual and his rights, his desires, his present and future hopes. But when we see how, in crisis situations such as the one we are in now, our programs for social advance are questioned as expendable, as luxuries, we must admit that we have failed to make our own trust and confidence in these programs clear to others. It behooves us to restate this confidence. And to restate it so convincingly that even the most ingrown individualist can not only tolerate it but accept it as his own.

It may be unnecessary to say it, but I want to make it clear that I am using the term welfare in the broadest sense, to include, as does the World Health Organization's definition of health, the total well-being of people in our society. Many professions contribute to it; it includes the family, the community, the Nation; it means health, education, employment, and economic security, as well as provision of social services; it means full opportunity for the development of a healthy personality for each new member of our society as he or she comes into being.

Concern for the well-being of individuals is the essence then of our concept of social welfare. One of the wisest acts of our forefathers was to imbed in our Constitution—as an

eternal reminder to us—this concept that individual well-being is something that we must unite to achieve. It is not something that each of us plucks for himself. "To promote the general welfare," as our Constitution says, was one of the primary purposes for which we created this Nation. And the purpose of uniting to promote the general welfare was to achieve the greatest possible degree of security, happiness, freedom, and well-being for each individual.

I have the privilege of serving as Chief of a Bureau of the Federal Government which was created to give meaning to this phrase in the Constitution. The act creating the Children's Bureau is significant because it is a recognition that the struggle for the well-being of your child cannot be won unless it is won for all children.

In a living democracy there can be no separation between individual and social well-being.

Now individual well-being calls for many things . . . things of the body

and, what is much more important, things of the mind and the feelings.

As I see it, each of us is best able to function when we see ourselves and our environment in perspective; when we can share our purposes with others and trust each other and ourselves; when we are not afraid to question, or to use our imaginations; when we accept limits; and when we have courage and strength to fight when fighting is called for.

These are things of the mind and the feelings. And they are the stuff of life for most of us. Some of us do a fair job of achieving these qualities. But none of us achieves them entirely "on our own." All of us must have help, from our families, our schools, our communities and their institutions, our Nation . . . yes, and from the world. Some of us have need of special help in acquiring that quality of strength that makes it possible for us to function without doubts about ourselves, with trust and generosity toward others.

Social welfare has many goals, but

When day-care services are planned for children of working mothers, skills from many fields need to be drawn upon, such as health, social work, and nursery-school education.



Dr. Eliot gave this paper at the California State Conference of Social Work, held at Long Beach, Calif.

one of its major goals, I am convinced, is to find the way to give that extra ounce of support to those individuals who need help in finding their strengths so that they can build on them.

Critics say that programs designed to underpin the economic and social well-being of people make people soft, indulge them in alleged laziness, shiftlessness, or vanity. They say the money we dole out buys sister a fur coat. Or when it doesn't do that, it encourages her to have babies out of wedlock. These things we resent.

But I must say, in fairness, that the problem is largely one of understanding on both sides. The purpose of social-welfare programs has not been sufficiently well interpreted to the general public, and social-welfare workers still need to understand more fully the forces, the traditions, the cultural patterns that underlie the criticisms.

Democracy and the individual

The purpose of social-welfare effort is simple and clear. It can also be persuasive. It starts from the premise that each individual has a uniqueness of power, and that each individual develops best and accomplishes most—for himself and for society—when he has a chance to develop along the line of his own strength, however feeble or strong it may be.

This is, and this must be, the basic premise of a democratic society in all its activities.

Once the idea becomes clear that the purpose of the social-welfare program is to help individuals discover what they are best at doing so that they can do their best, most of the cynical and hostile criticism of these programs will evaporate.

I will go even a step farther and say this: Once the idea becomes central in our culture that, as Harry Overstreet says, "a man is *at* his best when he is *doing* his best at what he *can* do best," then the need for at least some kinds of social-welfare programs will disappear.

At no time in its history has our Nation been in greater need than

right now for competent, well-integrated, productive citizens. Instead of decreasing programs that make for social well-being and better human relations, we should be strengthening them. Instead of cutting their budgets, we should be zealously protecting their priority to funds, in the interest both of national and individual well-being. The problems that

services, medical and hospital care when sick, vocational counseling, and above all warm and congenial family life. But, as you and I well know, the picture is not as rosy as this for hundreds of thousands of our children.

Today there are 1½ million dependent children in families receiving Aid to Dependent Children under the Social Security Act. We are proud



Today 1½ million children are enabled to remain at home through the Aid to Dependent Children program. But in some of the States the living afforded these families is meager.

many individuals encounter in functioning as competent, well-integrated, productive citizens in peacetime are compounded when the threat of war hangs heavy over us.

But it is not only external threats that make the support of our social-welfare programs essential. We have the obligations that a democracy has toward its citizens who need help.

My first concern, naturally, is with the well-being of children. After seeing the wretchedness that surrounds the lives of so many millions of children in other countries, I am well aware of the advantages that the great majority of our children enjoy—life in a free community, education, good housing, recreation facilities, play space, health and welfare

that we have such a program that assures home life for these children. But we cannot take pride in the meager living that ADC affords many of them in some States, nor in the punitive attitude some people take toward mothers who need this help to hold their families together.

Juvenile delinquency is on the upgrade again, if we can take as an index the number of youngsters who become known to the police or are brought before our courts for delinquent acts. More than 350,000 delinquent children, now appearing in juvenile courts in a year, are a stark reminder of the many deprivations, neglects, and inequities which children suffer, and of the lack of warm parent-child relations in many fami-

lies. Between 50 and 100 thousand young delinquents are detained in city and county jails, places where no child should ever be housed. The 30,000 boys and girls in training or correctional schools for delinquent children are still another prod to our consciences.

In an ever-increasing number of homes today, the mother as well as the father has a job and is away from home for long hours. Suitable day-care services for children of working mothers—and there are well over 6 million such children today—are all but nonexistent in many communities.

Our State crippled children's agencies have on their waiting lists many thousands of children whose only hope for medical or surgical care rests in agencies that do not have adequate funds to provide such care.

Health and welfare agencies are doing good jobs for children in many communities. But hundreds of thousands of children live in areas that such services rarely if ever reach.

Of all our children, some of the most disadvantaged are those in families of migrant workers, those who grow up in isolated communities such as mining and mountain towns, and children who are members of minority groups clustered in urban and rural slums. The conditions under which many of these children live are a blight on our national life.

Democracy has much unfinished work to do for such groups as these.

How can the promotion of individual well-being best be accomplished? Belief that social good is achieved through concern for the welfare of individuals leads away from generalities to some practical measures.

In the field of social service, I sometimes wonder whether too great a concentration of effort has been placed upon measures that will remedy or mitigate difficulties that have already happened. The preventive approach that now dominates public health has not yet been developed as effectively in the social-welfare field as it should and will be. Planning for social services too often has had to be restricted to children and adults in

special need. This does not reflect on the planners as much as it reflects the limited understanding the public has of the positive role that social welfare can play. Even in public health, where preventive programs have long been accepted, it is only comparatively recently that workers have made organized efforts to promote sound mental health and directed their efforts against the social conditions that undermine it.

Health and welfare interrelated

This growing recognition of the importance of emotional factors in individual well-being is changing the concept of needed measures in both health and welfare fields, and drawing these two fields closer together.

As public-health workers come to see that few individuals can be truly healthy when they live in an atmosphere of suspicion and doubt, or when their opportunity to live decently is continually threatened by advancing living costs, they find that they must reconsider what preventive health work calls for.

So, too, social-welfare workers find that they cannot be content with measures aimed at aiding only those who have fallen by the wayside. They, too, must do preventive work and reach children and families before damage is done. This means programs for children in their own homes, in schools, in playgrounds. It means working ever more closely with health workers, who have ready access to the homes of nearly all families.

Important as preventive measures are—measures that seek to assure that physical, social, and emotional growth shall proceed satisfactorily—we cannot, however, concentrate on them to the exclusion of measures for aiding people who are in difficulty. Let me touch on some of the areas of work to which I believe we should give attention right now.

First on my list of problems of the welfare of individual children I have placed juvenile delinquency.

Preventing delinquency is to all intents and purposes the equivalent of promoting individual well-being. Its ramifications are so varied, its area

of operations is so broad, that it is indeed difficult to formulate the all-embracing program that might guarantee success. The prevention of delinquency and the study of its causes must, however, stand as our over-all purpose in any comprehensive program in this field. It involves all the best of the total welfare program. Those responsible for preventive welfare and health services should bear more constantly in mind that one of their goals—and a large and important one—is the contribution they can make to reducing juvenile delinquency. This is too often overlooked, usually because the connection has not been clear.

There are, however, certain specific things we must do for children who are already delinquent. It is from the ranks of these children that many adult criminals come. For national as well as individual welfare, we must do all we can to restore to full social and emotional well-being the children who engage in delinquent acts.

Recently, the press of the Nation has been greatly agitated about one manifestation of delinquent behavior, the use of narcotics by juveniles. Although this problem seems to be acute among certain groups of children, reports indicate that it exists mostly in large cities, and it may not have the proportions that popular reports have given it. Nevertheless, there is still a major job to do in controlling sources of supply and in assuring that the laws regarding the sale of narcotics are strictly enforced. Much more attention must also be given to discovering the causes of drug addiction on the part of young people and to rehabilitating those who have acquired this fearful habit.

To work effectively with juvenile delinquents calls for many skills that, as a Nation, we have still to make generally available. It requires that a better job be done in equipping for this work police and probation workers, judges, and institutional staffs; it means special training for child-welfare workers, teachers, and doctors, who see many of these children before they become known to police or courts. We must concern ourselves more with problems of the

delinquent's family and with the social conditions under which they live. We need skilled workers, whom we do not now have in sufficient numbers, to carry on effective programs of treatment and rehabilitation. This includes psychiatrists and other workers in child-guidance clinics. We need special study homes or other provision for diagnostic and treatment facilities. We need to know much more about how delinquents are handled in detention homes and institutions, what are the best methods of treatment, and what are the subsequent careers of those who spend time in jail or correctional institutions.

If all of us in the social-welfare, education, and health fields were to put our minds to it we could evolve a long-range program that would not only improve this situation but contribute greatly to the well-being of many thousands of children and adults.

Second on my special list of areas of work for children is the care of children who must live away from home all or part of the time, either in foster-family homes or in institutions.

Dr. John Bowlby, a distinguished child psychiatrist of the Tavistock Clinic in London, in a recent monograph published by the World Health Organization, reviews scientific evidence from many countries regarding the effect on children of separation from their mothers. He comes to the conclusion that this is a very hazardous undertaking. In the light of Dr. Bowlby's observations, it certainly behooves us to study various aspects of this problem and to examine very carefully our criteria and our practices in placing children away from their own homes.

It is also important to determine how day-care services can best be given, what the most helpful joint contributions of teachers, doctors, nurses, and social workers can be, what we can learn from the experience of nursery-school educators.

Day care for children is a problem that is likely to remain with us indefinitely. We in the Children's Bureau are inclined to agree with Dr.

Bowlby that it is best that mothers of young children stay at home with their children whenever the strain of doing so does not outweigh the advantages. Nevertheless, it is only realistic to recognize current developments and to insist that, if mothers are to be employed, services for the day care of their children be provided, and that these services be conducted in a way that conserves and advances the children's well-being and makes for their future mental health.

Federal funds can, under the "Defense Housing and Community Facilities and Services Act of 1951," be made available for day care in critical defense housing areas. But whether they will be appropriated, and how soon, I do not know. Of course you know that grants to States for child-welfare services under the Social Security Act can be used in promoting day-care services. The grants are not yet adequate to provide much in the line of direct services, but they can be effectively used for consultation to communities and for planning.

The third area of work that I want to emphasize is research and evaluation of operational programs. This applies to the child-health as well as the child-welfare fields. It involves a great variety of study methods and without question must be multidisciplinary in its approach.

The maternal and child-welfare programs under the Social Security Act are now 17 years old. Some of the State and local child-health and child-welfare programs are much, much older than that. It is high time that we in the States and communities and in the Federal agencies developed better yardsticks for measuring how well we are doing our jobs. Progress should be made in this direction, not only because funds must be well spent, but, even more, because the objectives of our programs have great meaning for the national welfare when they are well conceived and the ways of achieving them effectively designed and carried out.

Along with evaluative studies should go research of an operational nature that will produce facts on

which decisions about new programs, policies, and working methods can be based. For example, we need to know more about the kinds and costs of health service and medical care received by children in rural as well as in urban areas; and by children in special groups, such as those in migrant families, ADC families, and children in institutions. We need to study methods of improving the quality of care for such children. We need to know what becomes of children who for one reason or another are refused care or public assistance. We need to know more about the end results of adoption practices in terms of the mental health of adopted children. The same is true for children in institutions. Answers to questions like these would give us much to go on in our everyday work. They might also prove an effective means of showing the public why health and welfare programs are so much needed.

Basic research needed

Evaluation and fact-finding of these types, however, are not enough. More basic research in the social and biological sciences should be going on. Our work is seriously handicapped by lack of adequate understanding, for example, of the values and customs of the various subcultures in American society and how they relate to the origins of delinquent behavior. We recognize premature birth as problem number one in reducing infant mortality, but we know too little about the psychological and physical conditions producing it. The choice of operational or basic research to be fostered could well be guided by questions arising in everyday program activities.

There isn't a business of any size in the country that is operating successfully and keeping up with its market that does not earmark funds for research. Despite the fact that legislatures and social-welfare boards are composed largely of persons who are already persuaded of the value of market and product research, it is usually hard to get appropriations for research in the social-welfare field. I wonder whether much of our problem is not our own lack of con-

viction that research in the social sciences must be a part of all welfare programs if progress in practice is to be continuous. Or is it that methods of investigation in the social-welfare field need to be set up? Or, again, is it that we are satisfied for the time being with present practices, while we wait for the gaps to be narrowed between our present knowledge and the extent to which that knowledge is put to work? Do we sometimes hesitate to seek new facts for fear they will add more work to an already overburdened staff? Let me suggest that well-directed research, especially that of an operational or methodological nature, may well simplify rather than complicate existing programs. Whatever the reason for the inadequacy of research, it seems to me to be imperative that new impetus be given to research that will provide the facts upon which programs in social welfare will be based. In such a program the central idea should be the search for ways of furthering individual well-being in our modern complex society.

I can only touch on two more aspects of the social-welfare program—more and better training of more workers, and increased citizen participation in our programs—but the

space I can give to these is no measure of their importance.

Again and again, experience has shown that effective service to people calls for skilled, trained workers. We could do a far better job of strengthening individuals and of helping families if more of our workers were given help in getting the professional skills they need. Too few boys and girls are preparing to enter the social-welfare professions. Vigorous campaigns for recruitment of new workers must go along with expansion of training opportunities for the workers we now have.

None can stand alone

At the beginning of this paper I said that none of us can achieve a genuine feeling of well-being "on our own," or in isolation from the rest of the world. Gradually, through such participation, especially in local groups, there will spread a more thorough understanding and appreciation of the purposes and underlying principles of the total welfare program.

In working with the World Health Organization, it was brought home to me again and again that typhus and typhoid fever, dysentery, and malaria have no nationalism. Maybe

we in the health field have a special obligation to remind others also of the simple fact that the well-being of people everywhere is interrelated.

I cannot urge on you too strongly support of the programs of the United Nations and of the specialized organizations affiliated with it, which are attempting to improve the opportunities for better living for the children of the world. Our own technical-assistance program has great potentialities, too, for making the world a safer, more decent place for children. I share with Mr. Justice William Douglas the hope that wherever our Point IV program goes, with its technical and economic help to other peoples, it goes accompanied by a "Point V," the spirit and convictions of 1776, out of which our ancestors framed a government dedicated to promotion of the general welfare, and, I might add, to the rights of peoples to self-determination and self-government.

When we give assistance to so-called underdeveloped areas for agricultural and industrial development, we should give support at the same time to programs in the spheres of health and welfare which go hand in hand with economic development. Let us not be guilty of encouraging others to make the mistake we made in our own country for so long in concentrating on expanding our economic resources and neglecting the well-being of the human beings for whom those resources are intended. The time to plan programs of social advance is not after great wealth has been built up, but at the start of programs for economic development.

In these critical times we must be more alert than ever to express our conviction that social-welfare programs do contribute positively and effectively to furthering individual well-being and the general welfare. We do not have to persuade ourselves of this fact. But we do have to spread confidence that it is so, and to make very clear to the public our conviction that the long-time emergency we are in requires the utmost in preserving and enhancing every human resource we have.

Some of the most disadvantaged of our children are those in families of migrant workers.



HOW CAN WE EVALUATE SOCIAL WORK?

HELEN LELAND WITMER

THIS PAPER might well have a subtitle: An interpretation of social research to the social-work public and a plea for help. Year after year, for about 30 years, speakers before this Conference have urged that social workers give serious attention to the business of evaluating their work. Dr. Richard Cabot, in a presidential address in the early 1930's, startled the Conference by insisting that social work should follow medicine's example and determine the effectiveness of its services. Others had said much the same thing years before, and annually we listen to the same plea. Persons outside the profession are perhaps even more insistent that social workers should determine how much they accomplish.

In view of all this, why have we as a profession generally and we social-research people in particular been so slow in getting ahead with this task? There are various answers to that question: Lack of money, of time, of professional skill; unwillingness to face possibly unpleasant facts; and so on. All these are easily understandable. But there is one answer to which insufficient attention has been paid: The inherent difficulties in evaluating so tenuous a thing as social work. These difficulties are well known to research workers. I think, however, that we in research have hugged them to our bosom too fondly; they are so precious, so esoteric, so useful in protecting our sense of self-esteem. It might be better if we showed them to the rest of you—even at the risk of having them disappear.

The first problem we face in attempting to devise a scheme for judging the effectiveness of social work is that of goals or objectives. In medicine—our favorite analogy—effectiveness is judged by lives saved, by the crippling effects of diseases and disorders being eliminated or re-

duced, by the progress of the disease being halted, and so on. What are the comparable aims of social work? What do we expect the accomplishments of social work, successfully carried on, to be?

Goals seem clear

Offhand, it would seem as though that question could be easily answered. We expect social work to reduce the number of delinquents, to result in fewer parents neglecting their children. If the claims of the drives for funds are to be believed—the man-on-the-street says—social work should mean fewer broken homes, fewer children separated from their parents, fewer old people living in extreme poverty. And so on.

The trouble with this kind of test, however, lies in that word "fewer." Fewer than what? Obviously we mean "fewer than there would have been if there had been no social-work services." But this is not the same as saying "fewer now than there were in the past." Conditions may have changed in such a way as to make for an increase in separations and divorces, a decrease in jobs for old people, a greater likelihood of delinquency—and for these changes social work is neither to be credited nor blamed. This being so, no easy test of social work's effectiveness is to be found in comparing the present with the past or in noting the incidence of maladjustment generally.

The criterion "fewer" may, however, be taken to refer to change in particular cases. The X family exhibited such-and-such behavior before a social worker entered the pic-

ture; subsequently their behavior changed for the better in certain specified respects. The improvement is credited to social work, and we say that the number of maladjusted families is fewer by this one case. But can we be more sure of cause-and-effect relationships in individual cases than in communities generally? It is again a matter of past and present, and the possibility of numerous other factors having influenced the situation so that the part that social work played is far from clear.

But to come back to social work's objectives. It is probably too easy an answer to say, for example, that we expect social work to reduce the incidence of delinquency or marital discord or even to make the repetition of such social disorders less likely in individual cases. Do we aim to achieve these outcomes regardless of psychological cost to the individual concerned? Would it be adequate to achieve reduction in delinquency by extremely punitive methods? Is marital discord to be lessened through the wife—or husband—becoming utterly subservient and submissive? These may seem foolish examples but they highlight the fact that social work aims not at suppression of symptoms but at some other kind of change, the nature of which is difficult to state in general terms.

The question of social-work objectives in particular programs or with particular types of individuals would be easier to answer if we could agree what social work in general is, what it is for. A conception of the basic function or functions of social work would provide a touchstone from which the analysis of the aims of particular programs could take its start. Lacking such an agreed-upon conception, we are forced to determine for each particular program its *raison d'être*, without reference to general principles.

The lack of a unifying conception of social work's function also means that we have no way of assessing a

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Dr. Witmer gave this paper at the seventy-ninth annual meeting of the National Conference of Social Work, held at Chicago.

community's over-all need for social services or of determining the extent to which this need is being met. I do not mean to imply that this need for service could be easily determined if the general purposes of social work were established. I only mean that lacking clarity on social work's function, we cannot even consider the measurement of need. And, vice versa, it is not possible to use as a measure of social work's effectiveness the extent to which the need for social services, generally speaking, is met.

When we turn to particular programs and try to line up what their objectives are, we have to deal with the possibility that the sponsoring group, the professional staff, and the clients may have different ideas on this subject. It seems to be an accepted principle of casework that if professional worker and client cannot get together on this matter of aims little can be accomplished. There are those who maintain that in the long run the same principle holds for professional staff, and boards, and contributing public also. At any one time, however, a difference of opinion on this matter may exist, and it then becomes a nice question whether the accomplishments of a social agency's program are to be judged on the basis of the kinds of changes the staff aims to produce, the kinds the contributing public wants to see brought about, or whether it is to the clients that we should look for finding out what they think of the agency's services.

Involved in these distinctions is also the fact that the sponsors of a program are likely to have absolute standards and the social workers and clients relative ones. The sponsors are inclined to want to know, for example, how many children are no longer delinquent, how many families are no longer in need of aid of one kind or another. Caseworkers and clients are probably chiefly concerned with "movement" — with whether things got better rather than whether some ideal goal was reached. Closely related to this, too, is the caseworker's idea that social service is a help in time of trouble but no guarantee that trouble will not recur.

With objectives of a social-work program frequently so difficult to determine or at least to agree upon, it is easy to see why evaluative research does not flourish lustily. But even if goals can be set, the difficulties of evaluative research do not cease. The next step that must be taken is to decide upon criteria by which success, however defined, is to be judged. Whether this is difficult or not will depend in part upon the nature of the program's objectives.

What constitutes success?

If the aim of a program, for example, is a marked decrease in number of delinquents brought to court or in the individual child's delinquent acts, this step will be relatively easy. Even here, however, there will be differences of opinion. Such a question as how large the decline must be to be counted as a success will have to be considered, as well as the knottier questions of whether all offenses are to be regarded as of equal importance, whether first offenses count the same as repetitions, and so on.

The term "success" is more applicable when results are to be judged in terms of degree or kind of improvement in individual cases. Here criteria are often hard to define in ways that will be widely agreed upon and that will be similarly applied by various raters. And even if this is done, all is not clear.

For instance, after a great deal of careful work McVicker Hunt was able to draw up criteria by which it

could be reliably determined how much "movement" had occurred during the course of casework treatment of certain clients of the Community Service Society of New York. It was found, however, that these criteria were not applicable in a large proportion of the cases of the agency as a whole, either because the clients did not have enough interviews to yield information or because their difficulties were not of the sort to which the criteria applied.

Others who have tried to devise schemes for judging success, especially in that particularly difficult area, family casework, have found the going no easier. Whether we decide to judge results by whether the clients felt that they were helped, by what kind of solution of their problems they arrived at, by how well-adjusted they became or how long the improvement lasted, the problem of criteria and their reliability and validity is difficult to solve. This is not to say that the problem is insoluble; it is only to say that it will take hard thinking and painstaking work on the part of the profession generally—not only the research workers—before we shall be in a position to state definitely: "This is what a given social-work program or service is trying to accomplish, and these are the signs by which you can tell that the goal has or has not been achieved in particular cases or generally."

But even if we arrive at that happy stage, our troubles are not over. How are we going to demonstrate that

We feel that the social worker's efforts will bring good results, but how can we be sure?



social-work efforts produced or contributed to the so-called results? This is perhaps the toughest part of the research problem. We can firmly say that such-and-such are to be considered the objectives for the purpose of this study, that these are the goals with which this particular investigation deals. And after careful consideration we can draw up a list of signs or describe typical cases or even construct tests that will serve as guides for judging the extent of change that occurred during or after social treatment. But how are we to demonstrate that it was social work that did the trick?

The usual social-science answer to that difficulty is the control group. By this device the treatment in question is given to one series of individuals and withheld from another. This second series is chosen in such a way as to be as much like the first as possible, insofar as traits or circumstances likely to influence the kind of change under consideration are concerned. In comparable biological studies, the animals used in the control group come from the same pure strain as those in the study group. In biological and psychological studies of human beings, identical twins are often regarded as the best subjects.

So much is intangible

In social work—according to present theory at least—the traits of the client usually regarded as most influential in determining success or failure in treatment are such intangibles as personality make-up, the dynamics of the problem under treatment, the nature of the significant environmental circumstances (what is significant varying with the problem under consideration), and so on. This is not to say that such more or less easily determinable traits as sex, age, intelligence, nationality, and the like are of no importance. It is obvious, however, that individuals can be alike in these latter respects and still be very different so far as their need for the services of a social worker or their likelihood of dealing with their problems without such help are concerned. This we can probably agree on. The

tough problem, however, is how we are to secure for the control group a series of individuals whose personality make-up and characteristic ways of responding to difficulties is known but who have not received and are not to receive treatment?

It would take more space than we have here to discuss this problem at all adequately. It should be noted, however, that a few attempts at solving it have been made. In a study at the Jewish Board of Guardians, for example, children who had been examined and found to be within the agency's function and yet not treated were used as a control group. In the Cambridge-Somerville Youth Study groups of children were equated for various traits on the basis of individual examinations and home studies and then arbitrarily selected for treatment or control purposes. Other investigators have used projective tests or other such devices for quickly securing information about personality and psychological functioning. None of these methods has wholly solved the problem of getting comparable cases for control purposes, however, chiefly because some of the significant facts often cannot be learned until treatment is well under way.

Recognizing the difficulty of securing proper controls, social-work investigators usually pin their hope on intragroup comparisons. They reason that if the cases that turn out well can be shown to be different in significant ways from those that turned out poorly, a connection between outcome and the work of the agency is likely. For instance, if it is found that the cases labeled "success" were much more likely than the failures to have taken an active part in treatment, to have wanted treatment and found it useful, if many more of them than of the failures had traits that theoretically would make them better treatment "risks," then social-work investigators are inclined to say that the changes that took place in these cases were probably largely attributable to the treatment measures.

This, however, is not wholly satisfactory reasoning. It may be that in-

stead of indicating that social work can be helpful to certain clients in certain situations, these investigations have only identified the people who will solve their problems satisfactorily with or without the help of a social worker.

There is, nevertheless, an extension of this reasoning in regard to determining causal relations that holds promise. Briefly it is this. Granted that in any particular program the apparent success achieved may be explainable as above, what is to be said if similar studies are made in different kinds of programs aimed at, say, delinquency prevention, and it is found that one program appears to work with one kind of case and another program with another? Would this not greatly increase the weight of the argument that outcome and treatment are related? Vice versa, if in program after program the same sorts of boys turned up as the ones apparently aided, would this not suggest either that any kind of method works with these boys or even that such boys would probably get along all right without treatment?

Studies of this sort, if they did indicate causal relations, would have the additional merit of providing information on other important points. For instance, to keep to the delinquency example, they would provide much-needed basic diagnostic categories for distinguishing delinquents on the basis of treatment needs. They would also make possible the efficient use of treatment resources, for by the careful matching of delinquent and treatment measure the chance of good results would be greatly increased.

We need to find answers

It is said to be a good idea to end papers on a hopeful note. If so, this is probably the best point for ending what may have sounded like a discouraging account. I hope that, in this description of the difficulties that beset research when the effectiveness of social work is to be studied, I have not discouraged you but rather have aroused your interest in helping us research workers find the answers.

Reprints in about 6 weeks

A VISITOR'S VIEW OF CHILD WELFARE IN VIENNA

EDITOR'S NOTE: This is the second part of an article that began in our August-September issue. (We shall be glad to send a copy of that issue to any reader who missed part 1.)

H. TED and BUNNY RUBIN

In Vienna children with problems are usually sent to institutions rather than to foster homes. The basis for this decision is not a careful diagnosis and evaluation as to what setting would be best for the child. The determining factor for institutional placement, we should like to suggest, is that the usual Viennese family finds it very difficult to tolerate problems of behavior and personality. Typically, the mother is strong, domineering, and overprotective, and the father is either a feared figure who commands respect, or a genial, *gemütlich* person who plays a role not always easy to define.

Although the Viennese family is generally characterized as an affectionate one, this affection may often be used as a controlling device. Conforming behavior is rewarded with much affection, but affection is withheld when a child is resistive.

This can be a punishing environment for an aggressive foster child, and the restrictive atmosphere discourages the more inhibited child from any expression of his feelings.

Under these conditions, the number of effective foster homes is naturally limited, and it would also seem that fewer families would request that children be placed in their homes. In addition, the average Viennese social worker has little time for working toward helping foster parents to be more effective. It is generally felt that lay acceptance and application of established principles of child psychology is more advanced in the United States than in Austria.

There is another long road ahead in improving methods for studying and certifying foster homes. At present

the city grants a certificate after approving a report submitted by a *Jugendamt* social worker who has visited the home only once and has reported mainly the physical setting and surface attitudes.

The majority of Vienna's institutions for children are operated by the city. In 1950 the city's budget for its 20 such institutions, approximately \$1,000,000, covered total personnel, food, clothing, new furniture, and maintenance expenses. About one-eighth of the institutional budget over the past 6 years has been allotted to the reconstruction of damaged buildings, and completing this work will take another 5 years. Almost 3,000 children are in these institutions, and besides, many children are placed at public expense in private institutions. The cost to the city for this latter expenditure is charged to a budget different from the institutional one.

No existing institution is built on the cottage plan, and no new children's institution has been completed since World War I. The first cottage-type institution is now under construction. Family-group atmosphere, especially important to children who remain in an institution a long time, has been especially difficult because the large buildings are not divided into small enough units. Administration and program of the institutions have not kept up with modern methods; and the personnel, in most of them, lack knowledge of psychological factors in human behavior. Few institutions have a social worker, and still fewer have a part-time psychologist. It is difficult to imagine this as the city of Adler, Aichhorn, Freud, and Rank.

An outstanding exception is a pri-

vate institution for girls 14 to 21 years, maintained by the International Quakers. This home, with several associates of Aichhorn as consultants, successfully creates a free atmosphere, with each girl's individuality recognized and confidence placed in her as a person. Another Quaker institution, in which the city places some children, has been reorganized as a treatment center for disturbed children; it employs couples as houseparents in its approach to the children's problems. Only one other institution, a public one, does this. The rest have, for each group of children, a housemother and an *Erzieher* (counselor), or an *Erzieher* alone. The latter may live in the institution or may come daily to direct such group activities as arts and crafts, household chores, and study periods.

The city operates several institutions for the care of dependent and neglected children up to the age of 3 years. One is a large, central, hospital-like institution, which has 560 beds for dependent and sick children under 3. The emphasis in its program of care is overwhelmingly medical, and there is almost none of the warm, human contact needed especially by a small child. Toddlers are only slowly removed to foster homes, and babies under 1 year are rarely placed in such homes. A new mother in need may remain in the institution with her baby for a nursing period of 3 months, and if she finds it necessary to leave the baby in the institution longer she may visit him for regular feeding periods.

In the same building is a milk bank that buys excess milk from nursing mothers for distribution to mothers unable to breast-feed their babies. (With relatively few exceptions Viennese babies are breast-fed.) The milk bank also dehydrates milk for shipment in powder form to smaller Austrian communities.

One public institution specializes in the care of children from 3 to 6 years of age, and another offers short-term placement for children of various ages.

The city has converted an old

Hapsburg castle into a diagnostic center for school-age children. Children with more difficult behavior problems are sent here from the central reception center. After a 2- to 3-month observation and testing period, recommendations concerning treatment are made. This represents a beginning effort to use more careful methods in studying large numbers of Viennese children who have problems.

Vienna's vast anti-tuberculosis program, which has received international attention, sprang from the "black menace" epidemics that scourged the city after World War I. Each district has a TB center, which investigates home surroundings and which tests and X-rays children and adults. Extensive preventive and control measures also include careful study of school children's diet and health, as well as extensive use of health camps in the nearby mountain areas. Tubercular children are treated in three well-equipped institutions.

To help the handicapped

War injuries have, of course, increased the number of handicapped children. Efforts to meet their needs are made through a combination of special schools and institutions. For the physically handicapped, including the cerebral-palsied and the epileptic, some physical therapy as well as preliminary vocational training are given both in the schools and the institutions. Although Vienna has long provided facilities for its handicapped, its teaching techniques have not always kept up with modern methods. Lack of sufficient special equipment can, however, be understood in the light of present-day economic conditions in Austria.

For deaf children a federally operated institution provides both residential care for children from bordering provinces and day-schooling for those nearer by. Like the children in most other Viennese institutions, these children live in large units. The absence of any electrical hearing aids often thwarts the excellent efforts toward teaching these



Vienna's child-welfare program is only now beginning to recover from the ravages of war.

children oral language. Hearing aids, along with a much improved differential diagnosis concerning the degree of the child's hearing loss and his potentialities for learning to talk would enable some of these children to adjust to the city's day school for the hard of hearing. At this latter school also, lack of such aids similarly robs some children of a future in the more normal environment of the regular school.

Children with speech handicaps have long received therapy within the normal school setting. Retraining is done mostly through drill materials, with little emphasis on contributing emotional factors. Children with more involved language problems—organic or functional—may attend special clinics at the University of Vienna Hospital for individual or group therapy.

The rehabilitative work for blind children is done through an institution and at the school for the partially-sighted.

Various organizations are beginning to study how handicapped children can be better integrated with normal children.

Austria, including Vienna, is now developing an important program for all categories of handicapped persons, including children, under the auspices of the newly founded Austrian Society for the Rehabilitation of the Physically and Sensorially Handicapped. It is probable that significant developments can be expected in this field in the next several years.

Two institutions and many *Hilfschule*, or special schools, are devoted

to the education of mentally deficient children. The Viennese school system, with its high academic demands and lack of pupil individualization, presents great problems for the slower-learning child who is, however, not feeble-minded. Inaccurate diagnosis incorrectly assigns to these facilities certain children whose educational problems are not due to feeble-mindedness.

Many school-age children with emotional problems are removed from their homes to institutions. Even when such removal seems to be the proper course, lack of professional staff in these institutions often nullifies the purpose of the placement.

A pavilion of the Steinhof mental hospital houses 60 children—psychotic, grossly feeble-minded, epileptic, encephalitic, hydrocephalic, and undiagnosed—all without special grouping. Children here receive little or no individual psychotherapy, and even the physical care is primitive. There is one social worker for 2,000 cases in the entire hospital. With a prewar population of 4,000 patients, Steinhof had been one of the largest mental hospitals in Europe, but Nazi officials rewrote this figure by leading 3,000 patients into gas chambers.

A remarkable new experimental treatment center for epileptic children is now being set up, which offers great promise for the future.

The Federal Government operates Steinhof, as well as training schools for children adjudged delinquent and juvenile courts. Other personnel, who may be teachers or social workers

assist a judge in hearing each juvenile case. Through such a structure, the court seeks to associate itself more with educative and rehabilitative aims, rather than with punishment. Although some vocational training is given delinquents, the psychological and social-work services are quite inadequate.

However, a newly opened home, organized by the police to house certain neglected and vagrant children temporarily, is one of the most advanced of Viennese institutions. When a child leaves this institution, he or she signs the guest book, the same guest book that government officials and foreign visitors sign after inspecting the home. Here older children are addressed with the formal German "Sie," indicating respect for them as people.

From school to work

The age of 14 may be called the apprentice age, for at this time a majority of boys and girls leave school to begin training for their chosen trades. (Compulsory school attendance in Vienna covers an 8-year period between the sixth and the fourteenth birthdays.)

The city, recognizing the separate needs of youths who have left school, has created a number of special institutions for them. Young people from 14 to 18 years of age eat and sleep in these homes, studying and working at their trades during the daytime. In addition, several of these homes serve as temporary reception centers until the youngsters are able to obtain other living accommodations. Group activities are planned

for the evenings. As their stay lengthens the young people pay an increasingly larger share of the cost, since their small salaries increase as training continues.

At present a need is felt for a home for 18- to 21-year-olds. Such an institution could offer a healthy group-living experience for these economically self-sufficient young adults.

It should be noted that a movement has been launched to raise the compulsory school-attendance age to 16.

In addition to the services given by the counselor on the staff of the *Jugendamt*, psychological services for children are offered by several facilities. Two of these are in their early developmental stages. On the whole, such services are grossly insufficient.

The best-established facility for psychological services is the Children's Clinic of the University of Vienna Hospital. The director of both the psychiatric out-patient department and the residential diagnostic center for 60 children is medically oriented, with a firm belief in the physical basis of deviant behavior. His therapeutic approach is directed toward integration of the various centers of the brain through pedagogic methods. Comparatively little attention is given to the role played by the emotions or by environmental influences. No deep therapy is performed in the out-patient department. However, plans are being discussed for a children's treatment center nearby, and the first small development is under way in the university's psychiatric hospital, where

the approach will be from the standpoint of dynamic psychiatry.

Another diagnostic center has been developed within the past 2 years by the city's school system to provide testing services for school-age children. The standards of this center are high, and its director has extended the Bühler Preschool Developmental Test to school-age children and has adapted other tests that are currently used in German-speaking countries. In the near future this center will be enlarged, and its extended services will include special classes, with concurrent treatment, for neurotic children.

What is technically Austria's first child-guidance center was inaugurated in 1949 as a demonstration clinic. Simultaneous help to Viennese parents and children is offered through the team approach—by psychiatrist, psychologist, and social worker. The director, a psychiatrist, has an eclectic orientation, borrowing from both dynamic psychology and the prevalent Viennese physical approach. Like the psychiatrist, the psychologist uses play therapy, and in addition does testing and group tutoring. This clinic is one of the two Viennese training centers for social-work students who plan to become psychiatric social workers. Less than 2 years ago, the students in the first course ever offered in Austria in psychiatric social work completed their studies, which included some months' field placement in England.

Although not a psychological service, the new special experimental kindergarten, the famous *Sonderkindergarten*, should be described. The park-located, pavilion-type building was especially designed for six groups of children under comparative study. These include a control group of normal 3- to 6-year-olds, as well as a group of feeble-minded children, a group of children with speech and hearing handicaps, a group of the physically handicapped, a group of emotionally disturbed children who have a history of mental illness in their families, and a similar group of children who do not have such a history. (Originally a group of blind

About one Viennese child out of every seven participates in a preschool group experience.



children was to be a part of the experiment, but there were not enough such children of kindergarten age to bring in for this purpose.) In addition to the latest equipment and well-trained kindergarten teachers, the staff includes a social worker, a psychologist, a speech-and-hearing therapist, and a physical therapist.

Social group work is as yet comparatively unknown in practice in Vienna. A course in group work, taught by a psychologist, has been initiated by the city's school of social work. Aside from the after-school centers for school-age children, there are few recreational centers for children other than those provided by political parties.

The future trend of Viennese child-welfare work will probably be channeled along the two courses of (1) broad social planning and (2) further advances in social casework and in family services.

Housing and day-care centers are the first need. At the end of 1950 there remained 100,000 people without homes. But extensive housing projects, which had their first great growth from 1924 to 1934, are finally under construction again. From 1946 to 1951 the city allocated its total housing budget for reconstruction of damaged dwellings. Vienna considers housing its focal problem. City welfare authorities, basing their belief on similar experience after World War I, state that the number of children under their care will lessen considerably when more housing units are available.

Coordinated city planning will again include many day-care centers in the large housing projects, but the huge program will nevertheless fall considerably short of its goal of making places available in such centers for one-third of all Viennese children.

The second area, the further development of casework and of family services, depends almost completely upon the progress of the Vienna School of Social Work in conjunction with the *Jugendamt* and the *Fürsorgeamt* or Public Assistance Bureau. For its present students the

school is rapidly revising and expanding its program. The school has influenced community agencies to recognize the need for better-trained workers; the agencies have responded by providing more effective field-work placements. Actual practice of casework by students is beginning to replace the traditional observation or apprentice experiences. Men students, first admitted to the social-work school in 1948, now number about 15 percent of each class.

Casework courses throughout each of the four semesters have come to replace the former emphasis on pure theory. In the next few years the school plans to lengthen its curriculum from 2 to 3 years.

The development among social agencies of the practice of keeping case records and the exchange of ideas and teaching materials among the various schools of social work in Europe will help to advance the development of the Vienna school, which in turn will be able to contribute much to other schools. The school offers weekly classes on an extension basis for practicing social workers, conducts a special program to train supervisors, and plans to meet requests for similar courses for counselors and for psychiatric social workers.

Creative leadership in all aspects of social work training in Vienna comes largely from the Dean of the Vienna School of Social Work, Dr. Nuna L. Sailer, and her far-seeing courage and soundly progressive ideas. She is considered one of the most capable leaders in European social work.

In summary, Vienna's city government has a rich tradition of broad planning and legislation to serve the basic needs of its total population. It believes that the degree of its advance in social welfare is, like its music, a mark of its culture. Although dynamic psychology had its birth in Vienna, only now is it being incorporated in broad social-work practice. The end result of this trend will be a heightened cultural and social achievement for this city and in turn for Austria.

Nursing groups. After a decade of progressive planning, a two-organization plan for national nursing associations was adopted at the Seventeenth Biennial Nursing Convention, held at Atlantic City, N. J., June 16-20, 1952.

One of these two organizations is the previously existing American Nurses' Association, which continues under revised bylaws; the other is the new National League for Nursing.

The new League was established by amendment to the existing charter of the National League of Nursing Education; and two other organizations—the National Organization for Public Health Nursing and the Association of Collegiate Schools of Nursing—voted to dissolve and become part of the League.

According to Pearl McIver, R.N., chairman of the Joint Coordinating Committee on Structure, which recommended the reorganization, the aim of the new League is the best utilization, distribution, and financial support of nursing services and nursing-education facilities. All nurses, from every occupational field, will have the opportunity (and the responsibility) to plan jointly with allied professional workers and with the public in efforts to reach this goal.

The American Nurses' Association, which is an organization made up of professional registered nurses, will have full responsibility for all functions which should be carried out by the members of a profession. These functions include establishing standards for nursing practice, recommending desirable qualifications for nurses in the various nursing specialties, and promoting the general welfare of nurses.

The first national nursing organization formed in the United States came into being in 1894. This was the National League of Nursing Education, the group that amended its charter in 1952 as a step toward forming the new National League for Nursing. In 1896 the American Nurses' Association was formed, with the help of the NLNE. In the more than half a century that has elapsed since then, various national nursing groups have been formed; at one time there were as many as six.

The two-organization plan now in force, with its clear differentiation between the functions of the groups,

should enable Federal agencies whose programs are concerned with nursing to work even more effectively with these organizations than in the past.

Marriage and divorce. The marriage rate for 1951 (10.4 per thousand population) was 37 percent below the all-time high, which was reached in 1946 (16.5 per thousand), according to the Bureau of the Census, Department of Commerce. Divorces also fell off. In 1951 there were 2.4 divorces per thousand population (44 percent below the 1946 peak of 5.5 per thousand).

Guidance services for youth were reported by only one-sixth of the public schools in 1948. Even those schools reporting such services averaged only one counselor to every 398 students, and were principally in cities.

Deadline: October 15

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• FOR YOUR BOOKSHELF

MY SON'S STORY. By John P. Frank. Alfred A. Knopf, New York. 1952. 209 pp. \$3.

A father tells the story of his mentally retarded child, Petey. It is a moving story, written with emotion but without sentimentality. From the normal and happy welcoming of the new baby into the family it progresses to the first frightening illness, the diagnosis of untreatable brain damage, the struggle of the parents between belief and despair on the one hand and disbelief and phantom hope on the other. Then follows for the parents a period of trying to find a way to meet this problem in the way that will be best for the much-loved child and for themselves and their other child.

They decide to institutionalize Petey, but they have a most difficult time trying to find an institution that

will care for such a child. Eventually they find an excellent place, and the remainder of the book is concerned with the pain of separation and how the parents managed to put their lives together again into some sort of normal and satisfying pattern. Neither the anguish nor the courage of these parents is minimized.

Mr. Frank has not written this story for relief of his own personal grief, although it may have helped him. Nor has he written it to help other parents with mentally retarded children, although it could not fail to help them. His main purpose, it seems, is to make people understand what he means when he says: "No one knows exactly how many retarded children there are, but something over 10,000 of Petey's general class are born every year. I wish that families less well situated than ours could come out as well. We and our fellow Americans as a people don't do nearly enough to provide for these sick children."

Betty Huse, M.D.

CHILD PSYCHIATRIC TECHNIQUES; diagnostic and therapeutic approach to normal and abnormal development through patterned, expressive, and group behavior. By Lauretta Bender, M.D. Charles C. Thomas, Springfield, Ill. 1952. 335 pp. \$8.50.

As Dr. Bender explains in her foreword, this book consists of a collection of papers written by Paul Schilder (her late husband), herself, and a number of their associates at Bellevue Hospital, New York City, during the past 15 years. She credits Dr. Schilder with the authorship of 4 of the 19 chapters; she also credits him with being the "originator of most of the concepts, attitudes, and resulting philosophies expressed in all these papers." But the book essentially is still hers. The idea of an endeavor as vast as this is hers; so are the concepts, with and without variations from Freudian concepts; and so is the admirable execution of diagnostic and therapeutic techniques demonstrating the entity of the child as a personality.

Most readers familiar with child welfare and child psychiatry will find little that is startlingly new. Each of the various tests and psychotherapies, individual and group, has been elaborated on in the past. It seems that Dr. Bender does not wish to present conclusions other than those based on the experience shown in her abundant case material.

What is new is the integration of

all techniques, regardless of origin, theory, or type, in one volume, to serve the reader as reference and as stimulus for further thought.

Hans A. Illing

• CALENDAR

Oct. 1-31. Red Feather Month. Information from the United Community Chests of America, 155 East Forty-fourth Street, New York 18, N. Y.

Oct. 2-4. American Academy for Cerebral Palsy. Sixth annual meeting. Durham, N. C.

Oct. 2-5. Rural Youth of the U. S. A. Conference. Annual meeting. Jackson's Mill, Weston, W. Va.

Oct. 19-23. American School Health Association. Twenty-sixth annual meeting and twenty-fifth anniversary of the founding of the Association. Cleveland, Ohio.

Oct. 20. Association of Maternal and Child Health and Crippled Children's Directors. Annual meeting. Cleveland, Ohio.

Oct. 20-23. American Academy of Pediatrics. Twenty-first annual meeting. Chicago, Ill.

Oct. 20-23. National Conference of Juvenile Agencies. Forty-ninth annual meeting. Columbus, Ohio.

Oct. 20-21. National Safety Council. Fortieth National Safety Congress and Exposition. Chicago, Ill.

Oct. 20-24. American Public Health Association. Eightieth annual meeting. Cleveland, Ohio.

Oct. 21-24. American Dietetic Association. Thirty-fifth annual meeting. Minneapolis, Minn.

Oct. 23-24. National Midcentury Committee for Children and Youth. New York, N. Y.

Oct. 24. United Nations Day.

Oct. 26-30. National Society for Crippled Children and Adults. Twenty-ninth annual convention. San Francisco, Calif.

Oct. 27-30. National League to Promote School Attendance. Thirty-eighth annual convention. Boston, Mass.

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THE CHILD

NOVEMBER 1952



WHEN A CHILD MUST GO TO THE HOSPITAL

Much can be done to prevent emotional disturbances

RUTH WINKLEY

WE KNOW that children differ in the ways they meet difficult situations, and that a child who is well-adjusted, whose family life is a life of love, trust, and security, is the one who is most likely to go through his tonsil operation without much emotional disturbance.

But however well-adjusted a child may be, his first hospitalization may be full of disagreeable surprises. And some of the hospital procedures, especially if he misinterprets them, may frighten him or otherwise disturb him.

To find out which procedures were bothering the child most, a team of five professional workers—four physicians and a psychiatric social worker—have made a 3-year study of children undergoing tonsillectomy at Albany Hospital, Albany, N. Y. More than 100 children 3 to 8 years of age were studied — before they went to the hospital, while they were there, and afterward.

Children's resentment heeded

The study showed that what the children resented most was a jab with a hypodermic needle. And as a result this hospital has reduced the use of needles, and by the end of the study the only jab these children had to take while conscious was the finger prick for a hemoglobin reading.

Some other procedures were modified or eliminated, though many, of course, could not be.

But as a step toward making the whole hospital experience less disturbing to the child, the social worker—myself—visited the child's home a week or two before the operation, got acquainted with him and his parents, and talked over the various things

that would happen in the hospital. I especially explained the procedures that had been found most disturbing.

As for reassurance, I found that the mother needed this more than did the child. What the child needed was information. And that is what I gave, along with reasons for some procedures that we had learned were misinterpreted by some children in ways that had unhappy results.

I also studied each child, evaluating his emotional characteristics and his relations with his parents.

In order to bring to light the things that were disturbing the children, members of the study team considered the situation of each child from the time he entered the lobby of the hospital until he went home the next day. And they noticed a source of disturbance for a few children at the very beginning of their hospitalization—in fact, in the elevator. For a few children are afraid of shut-in places. And when such a child steps into the hospital elevator he is likely to become panicky. After we learned about this, I included elevators in the discussion with the child at home.

But even if the child knows about elevators, the hospital elevator may

be crowded, with many grown-ups towering above him and obstructing his view, and he may become frightened. If he has learned to count, it helps if he is told beforehand that he and his mother are to get off, say, at the sixth floor. Watching the floors go by and confirming the truth of this may sufficiently engage his attention to keep him from being afraid.

Then there are the "men in white." Many children have never seen doctors dressed in white, even on television. For an occasional child, seeing men in white clothes may be a scary encounter unless someone has told him about this ahead of time.

Another thing that may bring consternation is undressing and going to bed in the daytime. It may make a child feel that he is being punished, especially if that is the way he is punished at home. In this hospital a child does not need to go to bed when he arrives. The hospital has a large playroom, and there Johnny will find himself with other children, and this may take his attention away from his own troubles, at least to some extent.

When the real bedtime comes, however, Johnny may be distressed to find that his hospital bed has sides, like a baby's crib. If he is proud of his youth-bed status, the resemblance to a crib may bring with it a tinge of humiliation. But if he has been told at home about the kind of hospital bed he will sleep in, and if the reason for the crib-like sides is explained to him, he is likely to take the whole thing in stride. Therefore, when I visited a child in his home, I told him why his hospital bed would have sides—it is because the beds are so high and so narrow that even a

RUTH WINKLEY is Associate in Pediatrics at Albany Medical College, Albany, N. Y. She is a graduate of the University of Michigan and of the New York School of Social Work.

The members of the team that worked on the study Miss Winkley describes here are all on the staff of Albany Medical College. The director of the project was Otto A. Faust, M.D., Professor of Pediatrics. The other members, besides Miss Winkley, were Katherine Jackson, M.D., Anesthesiologist; Ethel G. Cermak, M.D., Associate Professor of Pediatrics; and Marjorie Murray Burr, M.D., formerly Associate Professor of Pediatrics.

The study was made with the cooperation and support of the New York State Department of Health.



A child whose family life is a life of love, trust, and security is the one who is likely to go through a hospital experience, such as a tonsil operation, without much trouble.

grown-up might roll over in his sleep and fall out.

Again, if Johnny wants to be Hopalong Cassidy both day and night, and is used to wearing cowboy pajamas (and something similar may apply to little Mary too), the hospital gown will seem a rather dull affair. There is something about being Hopalong Cassidy, even in the hospital, and about wearing one's own night clothes, that keeps many a little fellow from feeling he has lost his identity in this very strange place.

Mother's presence usually helps

In Albany Hospital, a mother is encouraged to stay with her child the 2 nights he is there and is permitted to sleep in the same room with him. This, too, is a boost to most children's spirits. During these 2 important days in his life Johnny has the assurance of his mother's constant presence in case he needs her. If Johnny and his mother are truly close, this is a good arrangement; but it can be disturbing if his mother is more upset than he is, as such feelings com-

municate themselves to children without words. Fortunately some mothers know this themselves deep down inside; and sometimes one of these will say that Johnny will be better off without her, and another lets herself believe that she is more needed at home.

Taking a blood sample is a routine requirement in the hospital, and, of course, Johnny will have to undergo this, often to his mother's distress. For most adults have disagreeable associations with blood; and it is hard for a mother not to transmit to her child her horror, or her association of blood with pain. Yet children, unless they have picked up this idea from adults, need not have any such feelings. If Johnny knows ahead of time that his finger will receive a slight prick, such as he gets dozens of times crawling around in briars at play, followed by the appearance of a round bead of his own beautiful red blood, he will probably watch the whole performance with fascination. Mother may be standing by, trying to keep from shuddering or cringing, but

Johnny watches without anxiety the bead of blood rise in the little glass tube, just as he was told it would.

Another routine procedure is to take a sample of urine. Johnny may feel a little strange about using a urinal. But if he has been told about it beforehand and nobody hurries him, he may be less disturbed. And after he is a little more used to his surroundings, he is likely to produce the sample readily.

For Mary this process may be a bit more embarrassing. Mary is proud of the fact that she is trained and never gets her bed wet. The bedpan with its strange feeling may make her think she has spilled in her bed, which she would never wish to do, especially in a strange place. A little description ahead of time of the bedpan and of how it feels, and assurance that it will not spill over, can make this procedure easier for her.

Anesthetist briefs Johnny

In the late afternoon a woman doctor, who is to administer the anesthetic the next morning, comes to see Johnny to get acquainted with him. She is wearing her operating-room costume, and she tells him that when he goes to the operating room tomorrow all the other people in the room will be wearing clothes like hers.

She says to him that he probably will not be sleepy when it is time for the operation because it will be daytime, but that she has medicine that will help him go to sleep so he will not feel anything when his throat is being fixed. She lets him smell this medicine, and shows him the anesthesia mask. He turns it over and tries it on his nose so that he knows just what it will be like the next morning. She tells him she will put the medicine onto the mask a little at a time, that he will become very sleepy, maybe dizzy-sleepy. Then, she says, he will go fast asleep and will feel no pain during the operation.

The anesthetist goes on to tell Johnny that when he awakens he will be back in his bed and that his mother will be there (if this is the case). She mentions to him that his throat will

be very sore, but that he will be able to take little sips of ice water when he feels thirsty. Each day after that his throat will be less sore, and she tells him that soon it will be all well.

Johnny learns also that on the morning of the operation he will have no breakfast, as that might make his tummy feel sick.

Tonight he will have his supper on a tray; he likes this.

room, there is the anesthetist he met the afternoon before. She hands him the mask, asking if he remembers what he does with it. He replies that of course he does, putting it on his nose and holding it himself. No one else touches it except the anesthetist, who tells him she is going to hold it steady for him.

Then the anesthetist says quietly that now she is beginning to put on

by mouth, and if he is sleeping it can be taken under his arm perfectly well without waking him.

Some doctors give penicillin to help fight any low-grade infection the operation might stir up. Such an injection would be painful, but there's nothing to it if Johnny gets it right after the operation while he is still under the anesthetic.

Sometimes after the operation the child is nauseated and sometimes not. At any rate he is glad to have the ice collar on his sore throat and to sip cool drinks.

Home visit repeated

During our study I visited each child at home a week or so after the operation and again after 2 months. The child was free to say just what he thought of the whole thing. Instead of major complaints, which used to be the rule, these children had rather trivial gripes, unconnected with terror and fear. It might be that being given vanilla ice cream instead of strawberry was the worst happening they could think of, or that the television screen in the hospital was not as large as theirs at home; some of them couldn't think of a single gripe about the hospital. Of course, we know that many children do not talk about feelings that are deep-seated. And it is true that at the time of this visit many of the children were still showing some adverse results of their experience, such as restlessness in their sleep. But by the time 2 months had passed, only 17 of the 105 studied seemed to be still affected.

Apparently these children went through the tonsillectomy with much less emotional damage than might have been expected. Much of this success was due to the understanding of the hospital staff and to their enthusiastic response to the changes in practice. But the changes have been made primarily through the efforts of the chief pediatrician (the director of the study), who has given leadership for many years in developing hospital practices in the interest of the children's emotional well-being.

Reprints in about 6 weeks



When Mary woke after her operation, there was her mother, as well as a friendly nurse. Pleasant awakening helps to minimize emotional disturbance caused by hospitalization.

When it is time for him to go to sleep he has a snug, comfortable feeling, for there in the bed across the room from him is his mother. He also has his favorite teddy bear, which always sleeps with him. Nobody in the hospital thinks that this is silly, but that it is a good idea to have whatever is familiar and comforting.

In the morning Johnny looks for the cart that he has been told will come rolling along to ride him to the operating room. And this time he rides right into the elevator on his cart. But this is not a surprise. He has been told about this too.

When he arrives at the operating

the medicine he smelled the night before. Johnny recognizes the smell and after a few moments may say, "I feel a little sleepy," or his hands, holding the mask, may slip down to his sides as he gets drowsier and drowsier. That's all there is to it! No battle, no holding down, and no feeling of a surprise attack.

We found that among the most annoying procedures for a child are taking his temperature by rectum and giving him an enema. And why not? Nowhere in history has anyone exclaimed with joy over an attack from the rear, so why should Johnny? In this hospital he will not be given an enema. His temperature is taken

INSTEAD OF "BLOOD-AND-THUNDER" RADIO

A noncommercial program encourages little children to learn through dramatic play

NANCY HARPER

SO FAR as children are concerned, everything on radio and television is educational. Every program that reaches them, regardless of the quality, teaches them something, and it seems high time for parents, and others interested in children, to pay more attention to what and how the children are learning from their new teachers. Of course a child is the same person whether he is in school, or at home in front of a radio or a television set. Whatever he learns from radio and television, it should reinforce, not destroy, what parents and teachers are trying to build.

As an experiment in radio programming, designed to give, over the air, some of the same kind of learning and fun and confidence that children would get in a kindergarten or nursery school, "The Children's Circle" goes on the air in Boston every day at 5:30 p.m. over a noncommercial radio station. In preparing the program, we draw on the resources and personnel of Boston's Museum of Fine Arts, Museum of Science, Children's Museum, and other organizations in the Boston area that are interested in children.

NANCY HARPER is a faculty member of the Nursery Training School of Boston. She is co-producer of "The Children's Circle," a daily radio program for children 2 to 6 years of age, which she describes here. She is the mother of two children, 7 and 5 years of age.

Mrs. Harper's radio program was begun in October 1951. It is broadcast on Boston's 1-year-old noncommercial, educational, FM station, WGBH. This station is operated with the advice and cooperation of the Lowell Institute Cooperative Broadcasting Council, whose members are the Lowell Institute, Boston College, the Boston Symphony Orchestra, Boston University, Massachusetts Institute of Technology, the Museum of Fine Arts, the New England Conservatory of Music, Northeastern University, and Tufts College.

Patterned on everyday children's everyday interests, each program is written in a series of brief episodes, generously interlarded with music and conversational periods, to avoid overstretching a child's attention span.

Each program lasts half an hour. It is given slowly; dramatic play is suggested; and time is allowed for the children to carry out the suggestions on the spot.

On Columbus Day, for example, historical material is woven in. Upon the program's suggestion, the children may act out how the boy Columbus was told that the world was flat and how he figured out that it must be round. They may climb up into their armchair "sailing ships" and start on the great adventure across the Atlantic Ocean, which, in their case, of course, is the living-room rug.

Again, a program in connection with science material about animal habits may start such a game as bears preparing for winter—storing up food and preparing their homes. And an hour or so later the children will still be "bears," eating their sup-

pers peacefully or going to bed under sheets that have become, by children's own magic, special caves for baby bears!

We keep up with the seasons

The program moves with the child's life—from fall experiences to winter ones, and so on.

Even before the days and nights begin to grow cold, coal or oil trucks arrive at people's houses; and children, for the first time, or with increased appreciation, learn where coal and oil come from, how they are carried to our homes, and what these fuels will do.

Cooler weather brings on a question: "Why must I wear a jacket just because it's fall?" And the program combines science material and stories and music to answer just such questions. At jacket-wearing time a child may find it hard to learn to zip a zipper and remember to button a button. A game and a story and radio-suggested practice on these exasperating problems give such necessary things importance and fun.

As fall days grow shorter, an elec-

This time the radio story is about flowers, and a picture book helps this child to enjoy it.



tric-light bulb becomes more important than it was in summer; and it needs explanation, along with the reason why a finger mustn't be poked into the light socket. A game about sunlight and shadows makes use of a light bulb, too, with the bulb playing the part of the sun, and the child's hand serving as a cloud, to cast shadows where it will.

As winter approaches and sunny bedtimes change to dark ones, fears and bedtime problems may crop up. But they can lose their sting when a dramatic game accompanies an evening program, like the one about the baby bears.

Another bear story involves a "treasure hunt," in which a present for the child's mother is supposed to be hidden somewhere in the room. This leads to a search—under every chair, behind every cushion, even under the rug. Then, somewhat as in Marjorie Flack's story, "Ask Mr. Bear," the child meets a bear and asks for help. Whereupon the bear in this radio story whispers to the child and tells him where the present is. It is in the child's arms—a great big bear hug—and he promptly gives it to his mother.

Violent play not always fun

It is true that the rocket ships and gun-toting cowboys on many radio programs demand and get children's rapt attention, sometimes resulting in violent and aggressive imitative play. But the amount of noise a child makes does not necessarily indicate enjoyment. On the other hand, a child may not make much noise playing at being a traffic policeman as part of a radio game, but he may enjoy it, and he may find it a step toward learning that his community really cares about him.

And excitement is not a satisfactory substitute for the confidence that a child acquires when he begins to experiment on his own—to find out through play what makes a shadow over the sun, why a cork floats and stones don't, why a kite flies, and what makes thunder.

The program comes into the home,



See! We found the star in the apple, just the way The Children's Circle lady said we would!

with the stories told as a mother or father would tell them, or a friend, or a teacher, to a child alone or with other children. No studio audience takes part, for this would probably only distract the home listeners. The program narrator permits sufficient time for the children to respond with words and action. Only simple activities are suggested; the children develop these themselves, without a standard that might be too hard to live up to—or too easy.

And their relaxed behavior during such a program is very different from the tense, edge-of-the-chair attention they give to high-powered blood-and-thunder programs.

The programs are recorded, and some of the recordings have been played for children in the Boston Floating Hospital; some of these children are in bed, while others are up and around. Among sick children the program appeals to a surprisingly wide age range—under 2 up to 15 in some cases. The little children are inclined to listen passively; the older ones with amusement and response. Because the program deals with the

everyday, comfortable things, it seems to offer more peace and quiet and comfort, not only to a child disturbed by illness, but to any young child who is tired at the end of a day.

Programs can help parents

It is not easy to help a child feel at home in a world that is often too complicated even for adults. In this effort parents need any help they can find, and increasingly they are learning that help can come from radio and television. And radio, of course, reaches many thousands of children to whom television is not yet available (and who do not have nursery schools or kindergartens to go to).

Both radio and television are becoming part of the basic home education of children, preceding and sometimes overshadowing school lessons. The programs can make a child's world more puzzling and frightening than it already is—even more full of noise and violence. Or they can increase his enjoyment and understanding and self-confidence, and this is the aim of the program called "The Children's Circle."

DELINQUENCY PROJECT MOVES AHEAD

GROUPS and individuals all over the Nation are giving their full support to the recently announced Special Juvenile Delinquency Project sponsored by the Children's Bureau. This Project, on behalf of the Bureau, aims to focus national attention on the problem of delinquency and to stimulate community action toward improvement of services for delinquent children.

The Project, financed by private contributions to the Child Welfare League of America, has received many definite offers of assistance and cooperation in this campaign.

On July 14 and 15 representatives of 14 national agencies whose everyday concern is the prevention and treatment of delinquent behavior met in Washington to advise the Bureau on specific needs for helping delinquent children. The group emphasized the need for more facts about delinquency, for better training of the personnel who work with these children, and for a code of desirable practices to govern the services offered. The agencies represented at the meeting have offered to aid in fact finding and in furnishing consultation to communities undertaking improvements in their services.

Through the cooperation of the International Association of Chiefs of Police, one of the groups represented, a questionnaire has already been sent out to approximately 2,800 police departments in all parts of the country, asking whether or not they have officers who are trained for work with children; how many children are picked up by the police each year—and for what reason; and what procedure is followed for handling these various children.

The entire group of agencies will continue to act as an ad hoc technical committee.

The agencies represented at this meeting were: Administrative Office of the United States Courts; American Public Welfare Association; Bureau of Prisons, Department of Jus-

tice; Bureau of Public Assistance, Federal Security Agency; Child Welfare League of America; Field Foundation; International Association of Chiefs of Police; National Association of Training Schools; National Conference of Juvenile Agencies; National Council of Juvenile Court Judges; National Institute of Mental Health, Federal Security Agency; National Midcentury Committee for Children and Youth; National Probation and Parole Association; Office of Education, Federal Security Agency; and Osborne Association.

To promote local action

One week later, on July 21, in New York, the National Social Welfare Assembly called a meeting of its member organizations to consider ways in which they could cooperate with the Children's Bureau in this Nation-wide campaign. The 33 groups represented at the meeting have a membership which reaches into every community in the United States. The national organizations promised their full assistance in carrying information to their local chapters and in stimulating and supporting local projects connected with better services for delinquent children.

In addition, a number of the organizations reported that they would undertake work directly related to services for delinquents. The Girl Scouts, for example, are organizing troops in training schools. The National Council of the Protestant Episcopal Church will train chaplains specifically for work in training schools. Other groups indicated that they would explore this field of direct services. All the organizations represented at the meeting promised to reexamine their current programs, to see how effective they are in preventing delinquency and whether they can be adapted to better advantage in this campaign.

A summary of proceedings of an earlier meeting, the Conference on

Control of Juvenile Delinquency, has also stimulated widespread interest. This conference, held in Washington April 17-19 under the sponsorship of the Children's Bureau, was attended mainly by experts in the field of delinquency. The conference made recommendations affecting the operation of services for delinquents, the training of personnel, and the need for research in the field of delinquency. The summary of proceedings has been distributed recently to some 3,000 persons who work with delinquent children.

In his foreword to the summary, John H. Winters, Executive Director of the Texas State Department of Public Welfare and Chairman of the Conference, said: "The meeting in Washington was, in my opinion, the first step in a necessary process aimed at alerting leaders to the growing problems of juvenile delinquency. You, the reader, are called upon to use the structure we have created in order to continue building. Specifically, you are asked to consider the contents of this report and let us know what you think about it. We should be pleased to have the report used as a basis for meetings of persons concerned with the control of delinquency and to receive the minutes of such meetings."

Workers in a number of States have already reported plans for holding meetings such as Mr. Winters calls for. Among these States are Connecticut, New York, Delaware, and the District of Columbia. Numerous requests for additional copies of the summary continue to be received. A copy will be sent to any reader of *The Child* who requests it.

Pamphlets related to the work of the project will shortly be available. A special bulletin will be issued periodically to keep all persons interested informed about the latest developments. A copy of this bulletin also will be sent to any reader of *The Child* who would like to receive it.

CHILDREN AND THE SCHOOL-LUNCH PROGRAM

THE NOON LUNCHES that a child eats in the course of a school year have an appreciable influence on his health, his education, and his general welfare. The agencies represented on the Interagency Committee on Nutrition Education and School Lunch are concerned with one or more aspects of school-lunch programs. To assist all member agencies in carrying out such responsibilities as they may have, the Interagency Committee has prepared a statement of the values inherent in school-lunch programs. The paragraphs that follow develop the main theme of the statement of goals, which is that school-lunch programs should be centered on the child—his nutrition, his physical, mental, and emotional development, and his education.

1. The school lunch should foster good food habits and safeguard the health of school children

The noon meal served at school will fulfill its nutritional purpose only if it supplies at least one-third of the day's requirements for calories, proteins, vitamins, and minerals. Its contribution of nutrients should be such that, in combination with the breakfast and the evening meal typical of those served in homes of the community, the total daily needs of the children will be met. Food needs of children differ with their size, activity, and physical condition.

The school meal will serve as a safeguard of nutrition and health

The agencies represented on the Interagency Committee on Nutrition Education and School Lunch are: In the Department of Agriculture, the Bureau of Human Nutrition and Home Economics, the Cooperative Extension Service, the Farmers Home Administration, the Food Distribution Branch of the Production and Marketing Administration, the Office of Experiment Stations, and the Rural Electrification Administration; in the Federal Security Agency, the Children's Bureau, the Office of Education, and the Public Health Service; and the American National Red Cross.

only if it is so acceptable that it is eaten by the children in the quantities provided for them. Therefore, the quality of the food and its acceptability should receive due attention. School lunches provide a means for gaining acceptance of foods of high nutritive value, the increased consumption of which is in the interest of nutritional betterment. The school that serves only appetizing, moderately priced food under pleasant surroundings has taken an important step toward protecting children from unsuitable foods and beverages.

Sanitary safeguards are essential for all food handling, especially group feeding. The public health agency often has legal responsibility for the sanitary conditions and practices in school lunchrooms. Even if legal authority is lacking, this agency can provide valuable advice and assist-

ance to school administrators in ensuring that school lunchrooms meet accepted sanitary standards both as to facilities and operations.

The conditions under which the lunch is served affect the mental and emotional health of children. To this end effort should be directed toward provision of attractive surroundings, an unhurried quiet atmosphere, smoothly functioning service, servers who understand the children and their food needs, unobtrusive guidance when necessary in the choice of foods, and absence of any discrimination.

2. The school lunch should contribute to the education of the child and his family

The school lunch can provide a practical form of education in nutrition, sanitation, and social behavior for all children. It may also give practice to some pupils in planning menus; in buying, preparing, and serving foods on either a home or a commercial scale; and even in producing and processing foods.

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When a school serves only appetizing, moderately priced food under pleasant surroundings, it has taken an important step toward protecting children from unsuitable foods and beverages.



CONFERENCE WORKS TOWARD BETTER CITIZENSHIP

LUCILE ELLISON

THE SPIRIT of young America, vigorous and unafraid, was evident throughout the 1952 National Conference on Citizenship, held in Washington September 17-19. Seventh in a series, the conference was jointly sponsored by the National Education Association and the United States Department of Justice. In it were assembled 1,000 representatives of over 600 organizations and agencies, all deeply concerned with the rights and responsibilities connected with citizenship. They came from every State in the Union and from numerous foreign countries.

In each of the 18 groups, a cross-section of America came together. In the words of the summarizer: "You are, after all, America in miniature. There are some 1,000 of you, representing millions of doctors, lawyers, merchant-chiefs—to say nothing of the butchers, bakers, and candlestick makers. You are not all of one mind and I would be less than candid if I were to report that you were." Each conference group included a number of young people of high-school and college age and they were accepted as equals with the adults.

Some don't appreciate citizenship

Some pointed questions were asked in the various groups:

"How are our rights and privileges identified and acquired?"

"What rights and privileges seem most fundamental at this midcentury?"

"What are the most persistently troublesome problems arising from

the exercise of our rights and the enjoyment of our privileges?"

"What principles can we formulate, and what means can we employ, to improve the relationship of the individual citizen to his rights and privileges, as well as his duties and responsibilities, under the Constitution?"

First of the "troublesome" problems to be identified was the apathy of many citizens toward their constitutional rights and obligations as citizens. Such apathy, one delegate said, is in fact "subversive inactivity" because it plays into the hands of those seeking to destroy our democratic system.

Another problem, delegates suggested, is that young adults, for many different reasons, either do not or cannot exercise their rights. For example, because the voting age is fixed at 21, many younger people lose interest in and concern with their responsibilities as citizens.

The conference gave much attention to the practice of good citizenship. As one group reported: "It is not a matter of *knowing* right but of *doing* right." Said the summarizer: "There was one point on which you seemed all to be in complete agree-

ment. You couched it in different phrases, but the thought was this: Good citizenship demands action and participation. It is an active, not a passive thing."

The youth-adult panel on the opening evening of the conference presented the active role of schools in making better citizens. Dr. William S. Vincent, director of the Citizenship Education Project at Columbia University and moderator of the panel, said: "Since their beginning in America, schools have devoted a large part of their program of courses and activities to citizenship education. But the job is not an easy one and it is not a cheap one. More recently we have come to realize that you can't make good citizens solely by reading and talking about good citizenship. Good citizenship is a way of behaving. It is a matter of action, and if we know one thing about how people learn it is this: Active things you learn through action. Imagine trying to teach a girl to sew without a needle and thread. Active things require some sort of laboratory approach, and citizenship is no exception."

This panel also illustrated, as was true of the discussion groups, the integration of young people and grown-ups in the conference. In it, six high-school students, a judge of a juvenile court, and a newspaper correspondent took part. The students represented public, private, and parochial schools. From dozens of illustrations, it be-

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What principles can we formulate, and what means can we employ, to improve the relationship of the citizen to his rights and privileges, as well as his duties and responsibilities?



LUCILE ELLISON is a staff member of the National Education Association, Assistant Secretary of the NEA's National Commission for the Defense of Democracy through Education. Mrs. Ellison is assigned as staff liaison to the NEA's Citizenship Committee. In this capacity, she is a member of the Executive Committee for the National Conference on Citizenship.

FOR CHILD WELFARE IN VENEZUELA

ELISABETH SHIRLEY ENOCHS

FEW countries of the Western Hemisphere have made more rapid progress in the field of child welfare than Venezuela. In 1936, when a new Government was set up after the death of General Juan Vicente Gómez, who had ruled the country for more than a quarter of a century, one of the first official acts was issuance of a decree establishing a child-welfare agency. Plans were immediately laid for the country's First National Child Welfare Conference, held in 1938, to which the Venezuelan Government invited the Chief of the United States Children's Bureau as an honored guest. Shortly thereafter, in line with recommendations made at this meeting, Venezuela's Federal Congress enacted a Children's Code, which became the organic act of the present Venezuelan Children's Council (Consejo Venezolano del Niño).

Ten years later, in 1948, Caracas, the beautiful capital city of Venezuela, was host to representatives of all the American nations at the Ninth Pan American Child Congress. The delegation from the United States, of which Katharine F. Lenroot, then Chief of the Children's Bureau, was chairman, noted the great strides already made in work for children in Venezuela and the eagerness with which all branches of government—Federal, State, and local—were planning future progress. A draft of a new Children's Code had been developed under the leadership of a distinguished Venezuelan jurist who today is Minister of Justice, and that Pan American gathering reviewed the draft. Several of the United States delegates were members of the working group that reviewed the proposed code. A year later the Federal Congress of Venezuela approved that draft, with appropriate amendments, and the Code provides the legal authority under which the Ven-



In Venezuela, as in our own country, children are the nation's most important resource.

zuelan Children's Council now operates.

How the Council functions

In its structure the Council differs from many similarly named agencies in the other American Republics. In accordance with its basic statute it functions through an Assembly (Asamblea); a Board of Directors (Junta Directiva); a General Secretariat (Secretaría General); and 13 Regional or State Councils (Consejos Seccionales).

The Assembly is composed of representatives of the Federal Executive

branch of the Government and of the Ministries of Interior, Defense, Public Works, Education, Health and Social Welfare, Labor, Justice, and the Government of the Federal District. In addition to issuing regulations and reports, as prescribed by the Children's Code, it serves as a consultative body to the Council's Board of Directors.

The five-member Board carries the full executive and administrative responsibility of the Council; the Board's resolutions and orders are carried out through the General Secretariat.

Designed to serve the "whole child," the Council is largely the achievement of a far-seeing group of experts in the fields of pediatrics, public health, education, law, and social service. Its basic philosophy has been summed up by the President of the Board in the following terms: "... the goal of all programs of child care and welfare is to conserve the child in his own home, to strengthen family ties, to serve the whole child

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Mrs. Enoch has been a delegate to various Pan American Child Congresses, including the Ninth Child Congress, which was held in Caracas, Venezuela. She has also represented the United States at several of the meetings of the Directing Council of the American International Institute for the Protection of Childhood.

there, in his natural setting. The welfare of a people can be achieved only through the family . . . The home is the first line of defense against misfortune, against crime, against immorality and social crises . . ."

Direct service to mothers and children is offered through eight technical divisions.

The Division of Prenatal and Maternal Care sets standards and gives subsidies to maternity homes and postnatal centers founded by voluntary women's organizations. It has also established a nutrition center for pregnant and nursing women and has under study a national plan for family allowances. The Council works in close cooperation with the Ministry of Health and Social Assistance, which operates maternal and child-health centers.

The Division of Infancy and Pre-school Children cares for children from birth to 7 years of age through day-care centers and kindergartens. The Council's 41 day-care centers now care for 1,555 children, while its 25 kindergartens, in the capital and the several States, have a capacity of 1,609. Subsidies are also given to a number of private agencies providing similar facilities.

Dependent and delinquent children, as well as those with mental or physical handicaps, are cared for through a division called the Division of Minors in Irregular Situations. This part of the Council's program is largely the work of a psychiatrist, who was formerly Minister of Education and was the first Secretary General of the Council, Dr. Rafael Vegas. The program is generally referred to as the "Vegas Plan." A whole article might well be written about this Division; its boarding homes; its observation and treatment homes; its educational, scholarship, and apprenticeship programs—as well as about the plans for developing an effective system of financial aid to families to prevent many of the problems dealt with by these institutions. Through a technical advisory committee many types of professional skill are mobilized by the

Council to serve the needs of its wards, and special staff-development programs are being planned to improve the quality of care the children now receive.

The Social Service Division, with a staff of 58, has 27 offices throughout the country, including a few offices in States where as yet there is no regional or branch Council. The activities of the social workers are largely decentralized. In Caracas the social workers are assigned to work in the 14 maternal and child-health centers of the Ministry of Health and Social Assistance. The Division plans to extend this arrangement to other localities since it provides a basis for close and useful collaboration between social workers and public-health nurses. The social workers do casework and groupwork, child placing, and family counseling. They settle questions of parental authority and guardianship and refer certain problems to the Juridical Division.

As its name implies, the Juridical Division handles the Council's legislative matters. In addition to maintaining a legislative reference center it provides legal-consultation service, and through a staff of so-called "children's attorneys" it appears in court cases where the rights of minors are involved. In furtherance of its various programs this Division is now planning a series of "juridical seminars" for juvenile-court judges, children's attorneys, and Division staff.

The Division of Reports and Publications and the Division of Statis-

tics have contributed greatly to making known throughout the country the problems of child welfare and the services of the Council. The Administrative Division handles all details of purchasing, transportation, personnel, budget, and fiscal work for a program which last year totaled more than \$12,000,000. It is estimated that the Council's services reach four-fifths of the approximately 2 million children under 18 years of age in Venezuela.

A Cuban social worker has recently published in the *Revista de Servicio Social* of Havana the following account of her work in Venezuela:

"As a social worker I was part of a hard-working army on the staff of the Children's Council, carrying to the most remote and hidden hamlets of Venezuela the message of social justice and the material and spiritual benefits of the Council's work for children.

Social workers in short supply

"The social worker is an important member of the Council's staff, for it is she who studies at first hand each case referred to it and who deals directly with the child and his family or, through her reports, advises directors of agencies, doctors, attorneys, and judges of juvenile courts. Although a large number of the social workers graduated each year from the two schools of social work are employed by the Council, there are not enough to meet the needs. The Regional or State Councils send

Homes of families in Venezuela are often located in tiny hamlets hidden away in the mountains; and health and social workers are likely to find much difficulty in reaching the people.



girls on fellowships to Caracas for training in order to build up their own trained staffs in the hope of avoiding constant changes.

"From the beginning of my assignment, while I was in the capital, in the headquarters office, I was able to know and evaluate the great humane and social task of the agency. Caracas enjoys greater resources because of the collaboration given by the Ministry of Health and Social Assistance through its maternal and child-health centers and through the pediatric dispensaries of the Municipal Government. There are more agencies in the capital, better facilities for foster-home placements and for adoptions. There are likewise greater economic resources.

"The second phase of my assignment was in the State of Bolivar. This State includes, in addition to the State capital, Ciudad Bolivar, on the banks of the Orinoco River, the whole of Venezuelan Guayana with its enormous reserves of iron, gold, and diamonds. Yet despite its mineral wealth Bolivar is not one of Venezuela's richest States. It is inhabited by Indian tribes reached only by missionaries and explorers. During our stay we found, among the hundreds of cases passing through our office, which we handled or visited personally, a number related directly or indirectly to the Indians of those distant jungles whom we could not visit but to whom the Council's work was not unknown. I remember the case of an old Indian woman who came in from her distant tribe with a blind son to ask the 'Tribunal of Children' to find another son, 15 years old, who had run away from the tribe. The blind son was interpreter for the old lady, who spoke only an Indian dialect. Having registered her request she went away satisfied that the 'Tribunal of Children' would find her boy. And a few days later, as a result of telegrams, press notices, and radio broadcasts, the young Indian lad was on a plane headed for Santa Elena de Uaiaren, the last outpost reached by the airlines in Indian territory.

"Our last assignment was Merida,

the university town in the West on a plateau in the Venezuelan Andes, where I established a Regional Council. The preliminary studies took me to every part of the State—to towns, villages, and tiny hamlets hidden in the mountains. I interviewed authorities and neighbors, studying resources and needs. The opportunity thus offered me gave me a better understanding of the scope of this work that the Venezuelan Children's Council is doing for its future citizens."

For advanced study

During each stage of its development the Children's Council has sought the cooperation of experts from the other American Republics.

The President of the Venezuelan Children's Council, Dr. E. Santos Mendoza, has been most active in promoting international exchange of knowledge and experience with similar agencies in other countries. A few years ago, at Dr. Mendoza's request, Katharine F. Lenroot, then Chief of the Children's Bureau, made an agreement with him, according to which the Children's Bureau would undertake to supervise trainees—pediatricians, nurses, social workers, nutritionists, and so forth—who were sent to the United States by the Venezuelan Council for advanced work. Some assistance already has been given to three such trainees.

Last year Dr. Mendoza asked the Bureau to recommend a specialist in social groupwork to be employed directly by the Council to develop an in-service training program. The worker recommended by the Bureau accepted the position. And she has just returned from an 8-month assignment in Venezuela during which she taught groupwork to the Council's social workers as part of its program of staff development.

The cooperation initiated with the visit of the Chief of the Children's Bureau to Venezuela's First National Child Welfare Conference in 1938 has ripened through the years and shows once more that interest in the welfare of children is a strong element in promoting international friendship.

CITIZENSHIP

(Continued from page 41)

came evident that the school itself can be a civic laboratory that, with the help of community leaders, can broaden into the community, into the State, into the Nation, and into the world.

But, whether for youth or adult citizens, "On every liberty there is a price tag of responsibility," delegates agreed. Some of the responsibilities of the adult citizen, they pointed out, were:

To vote—regularly and intelligently, and in the primary as well as the general election.

To follow-up on voting by holding the elected officials responsible for their actions and conduct. At the same time, it is urgent that citizens aid actively in the development of a feeling of trust and confidence in the vast majority of loyal, honest, and capable public servants.

To obey the duly enacted laws of the land even though some individual pieces of legislation may not coincide with our convictions.

To pay taxes with as good a grace as possible and to seek information about the disposition of tax money in order to hold elected officials responsible for the wise use of it.

To support our country in armed conflict.

To oppose the activities of subversive persons and organizations, without, however, subverting the liberties that are guaranteed us by the Constitution.

To put public interest ahead of private advancement.

To speak out, even at considerable cost to the individual, in support of the rights of others.

To define rights and responsibilities in terms meaningful to the individual and to develop a program of action for meeting the problems involved.

To join with others in "making the Constitution live" by insisting upon a constructive approach which emphasizes the contributions that all individuals and groups are capable of making toward better citizenship.

SCHOOL LUNCH

(Continued from page 40)

The good school lunch, adequately publicized to parents by both children and school officials, can be a potent force in improving home food practices and in increasing nutrition knowledge among other members of the family.

Since the school lunch affords both health and education benefits, it is important that it be available to all children attending school who wish to partake of it. If charges are made for the school lunch, a plan should be worked out so that no child is excluded or is the object of discrimination because of inability to pay the full price of the lunch. All receipts from school-lunch operations ought to be used to provide the best possible lunches at the lowest possible price. In order that school lunches may be of maximum benefit to school children, community resources may need to be supplemented by outside financial aid for facilities, equipment, and upkeep, as well as for current operations.

In order to make the school lunch a school-wide educational project, it has to be administered by school officials and operated with the assistance of qualified workers, whether paid or volunteer. All individuals involved in a school-lunch program need to be adequately prepared for the responsibilities they carry. This statement applies with equal force to administrators, supervisors, managers, workers, and teachers. School-lunch workers should be selected because of their aptitudes, should be given adequate training for the job, and should work under competent supervision.

3. The school lunch should be a community-wide enterprise

Much of the success of a school-lunch program rests with the local community. It is the concern of parents and teachers, of the agencies responsible for or interested in community health and welfare in general, and of those with specific responsi-

bility for the health and education of the child of school age.

Community planning involving parents and citizens' groups, as well as civic and school officials, is essential for full realization of the potentialities of school-lunch programs. These planners should direct their attention to such essentials for successful school lunches as: Adequate financing, facilities, and equipment; sound administration; competent direction by individuals aware of the food needs of children, as well as skilled in management and supervision; and educational programs in both the school and the community.

Copies of this statement are available from the Nutrition Programs Service, Bureau of Human Nutrition and Home Economics, U. S. Department of Agriculture, Washington 25, D. C.

IN THE NEWS

Elizabeth Healy Ross, psychiatric social worker, took office October 1, 1952, in the newly created position of Deputy Chief of the Children's Bureau. As Deputy Chief, Mrs. Ross is working directly with Dr. Martha M. Eliot, Chief of the Children's Bureau, in directing the Bureau's programs of research in child life and administration of grants to the States for extending and improving maternal and child-health, crippled children's, and child-welfare services.

Before coming to the Children's Bureau, Mrs. Ross was for 6 years consultant to various Federal and District of Columbia agencies on development of psychiatric social services for children, for military personnel, and for veterans.

Born in Fort Dodge, Iowa, Mrs. Ross was graduated from the University of Minnesota and from the Smith College School for Social Work.

For several years she worked in child-guidance clinics. Then, during the 30's, she was a member of the staff of the Bank Street College of Education, New York City, where she helped develop a program of education for nursery-school and elementary-school teachers. This involved courses in child development and guidance. Following her work with the Bank Street College, Mrs. Ross

became admissions secretary and faculty member of the Pennsylvania School of Social Work, Philadelphia, Pa., where she taught, among other things, "Approaches to Work with Children."

While in Philadelphia, the major focus of Mrs. Ross' work was in the field of emotional growth of children. She gave courses to nursery-school teachers and to vocational-education teachers. She also served the Charles-town Play House, Phoenixville, Pa., and the Philadelphia Home for Infants.

During World War II, Mrs. Ross was Secretary of the War Service Office of the American Association of Psychiatric Social Workers, created with funds from the Rockefeller Foundation for the purpose of insuring maximum use of psychiatric social work personnel during the war period. She served as consultant in psychiatric social work to Dr. William C. Menninger, Chief of Psychiatry, in the office of the Surgeon General, Department of the Army, and has continued to advise on the military social-work program since the war.

Since 1946 Mrs. Ross has also served as consultant in the development of program, policies, and standards of psychiatric social work to several agencies—the Veterans Administration; the National Institute of Mental Health, of the Public Health Service; Walter Reed Army Hospital; and the Child Welfare Division, Board of Public Welfare, District of Columbia. She assisted in the preparation of the Fact Finding Report of the Midcentury White House Conference on Children and Youth.

Elected a member of the executive committee of the National Conference of Social Work in 1951, Mrs. Ross is a member also of the American Association of Social Workers and of the American Association of Psychiatric Social Workers. She was formerly on the advisory board on health services to the Chairman of the American Red Cross. Mrs. Ross' writings have appeared in various professional magazines.

Dr. Eliot and Mrs. Ross are assisted by Dr. Katherine Bain, the Bureau's principal consultant on health program, who continues to advise particularly on matters of program development for the Bureau as a whole, and Neota Larson, whose special area of work is administrative policy and legislation.

Melvin Glasser has been appointed Special Assistant for State and National Organization Relations on the

Special Juvenile Delinquency Project sponsored by the Children's Bureau. He will bring to this Project the full benefit of his experience as Executive Director of the Midcentury White House Conference.

Community and child. How communities can improve life for children was one of the principal subjects discussed by delegates from 30 nations at a 3-week seminar on Mental Health and Infant Development, which was held July 19 to August 10, 1952, at Bishop Otter College, Chichester, England.

The seminar was based on clinical studies of child development, made in France, the United Kingdom, and the United States of America.

The teaching faculty consisted of about 15 specialists from these three countries, and the delegates included doctors, psychologists, pediatricians, and social workers.

The seminar was sponsored by the World Federation for Mental Health, with the cooperation of UNESCO, the World Health Organization, the International Children's Centre in Paris, the United States National Advisory Mental Health Council, and the Grant Foundation of New York.

Young workers. According to Census estimates, in 1951 more than twice as many boys and girls under 18 were employed as were employed in 1940. Two-thirds of the 2½ million employed in 1951 were also attending school.

School enrollment. Data released July 21, 1952, by the Bureau of the Census show that, in October 1951, 99 percent of the children 7 to 13 years old in the United States were enrolled in school. (The age group 7-13 is included under compulsory-attendance laws in practically every State.) Of boys and girls 14 and 15 years of age, 94.8 percent were in school, but only 74.9 percent of those 16 and 17 years.

The high enrollment among children 7 to 13 years old—18,000,000—is due primarily to the presence in the elementary grades of a large number of children born shortly before World War II and during the war years, the report says. The number of children in this age group enrolled in October 1951 is 3,200,000 greater than the comparable number for October 1945.

Live births in the United States in 1951 soared above 3,800,000 for the second time in our history, and topped the 1950 birth total by more

than 200,000, according to preliminary figures from the National Office of Vital Statistics, Public Health Service, Federal Security Agency.

Moreover, the 1951 total may be an all-time high for the United States.

The number of children born in 1951 was estimated at 3,833,000 as compared with the 3,818,000 born in 1947, the previous record year. Because of the small difference between the two figures, it is necessary to wait for final data for 1951 before determining whether 1951 is definitely the all-time high.

The annual birth rate for 1951, based on registered births alone, rose to 24.5 per thousand population, an increase of 4.3 percent over 1950.

A fall in the infant mortality rate, which dropped for the fifteenth straight year, also helped to swell the 1951 addition to the infant population. Infant deaths last year occurred at the rate of 28.8 per thousand live births, contrasted with a rate of 47.4 in 1940 and 64.8 in 1930.

MCH services (preliminary figures). Under Federal-State maternal and child-health programs carried on under the Social Security Act, almost 395,000 babies under 1 year of age and 565,000 other children of preschool age attended health clinics in the calendar year 1951. This represents increases of 30 percent and 35 percent respectively over the numbers attending in 1950.

Physicians examined about 2,394,000 school children in 1951 under this program, an increase of nearly 8 percent over the 1950 figure.

About 189,000 women attended prenatal clinics in 1951, which was an increase of 8 percent over 1950 (175,000). There was only a slight increase in the number of expectant mothers who received public-health-nursing service (268,000 in 1951 and 258,000 in 1950). There was a 13 percent increase in the number of women who received postpartum nursing service—nearly 279,000 in 1951. The number given a postpartum medical examination—nearly 53,000—was nearly 12 percent below the number for the previous year.

DEADLINE EXTENDED TO OCTOBER 31

Owing to an unavoidable delay in sending out circularization cards to the official mailing list for *The Child*, the closing date for the return of the cards has been extended to October 31.

• FOR YOUR BOOKSHELF

SCHOOLS FOR THE VERY YOUNG.

By Heinrich H. Waechter and Elizabeth Waechter. F. W. Dodge Corporation, 119 West Fortieth Street, New York 18, N. Y. 1951. 197 pp. \$6.50.

This is the first book I have seen in which an architect and an educator join to give a comprehensive view of the physical and social needs of the preschool child in relation to physical equipment planned to meet these needs when he is in a nursery school.

The authors review the history of preschool education and give a picture of life in the nursery school of today. They believe that if an architect is to plan and design schools for young children, he should visit schools "to observe and experience for himself the great difference between the building as an inorganic structure of more or less formal beauty and the building which has come to life by its use."

Recognizing that no standardized methods of construction have been developed for these schools, the authors consider this fortunate, for the whole conception of preschool education is still in a developmental stage. As for their idea of how to construct a building for preschool education, they say that it is logical to draw on experience with construction of the two types of buildings most nearly related to it, namely, the home and the school.

The book covers such subjects as problems of layout and design; the relation of the nursery school to its neighborhood and community; outdoor equipment and playground surface; and the technological problems of lighting and ventilation, color, mechanical equipment, and furnishings. There are many photographs and floor plans, as well as a bibliography.

This book is "must" reading for all who are concerned with planning new buildings (or remodeling old ones) to give group care to young children.

I. Evelyn Smith

PRACTICES IN HOMEMAKER SERVICE; as reported by agencies providing the service on June 30, 1949. Federal Security Agency, Social Security Administration, Children's Bureau, Washington, 1951. Processed. 19 pp. Single copies free.

This study, made by the National Committee on Homemaker Service,

supplies social agencies with a set of facts on actual practices in homemaker service. It is a "working report," without comment or conclusions.

The report tells how 63 social agencies were administering their homemaker services in mid-1949. Fifty-six of the agencies were privately supported, 6 were publicly supported, and 1 was operated under combined private and public auspices. Thirty-two of those privately supported were family service societies, 19 were family and children's services combined into one agency, and 12 were children's agencies.

The agencies reported on five points: (1) On how the families came to them for service and how the original arrangement was made; (2) on their homemaker staff (number, work week, wages, training, etc.); and (3) on the professional staff (time the supervisor gives to the service, her education and experience, her duties, the line of authority, and the range of salaries); (4) on homemaker-service committees; and (5) on keeping the boards of directors informed about the service and letting the public know what such a service can do for families.

PRACTICAL GUIDE FOR FOOD SERVICE IN NURSERY SCHOOLS AND OTHER GROUP CARE CENTERS. By Edna Mohr. Elizabeth McCormick Memorial Fund, 848 North Dearborn Street, Chicago 10, Ill. 1951. 34 pp. 50 cents.

What types of foods should all young children have every day? How many meals should be served in order to meet the child's daily

food needs? What variation should there be in the amount and type of food served at different times during the day? How can an effective working relationship be maintained between the home and school in order to be certain that the child's food needs are met? How can the efforts of the home and school be unified in helping the child learn to like the foods he needs?

This guide offers concise, practical answers to these questions, based on the author's breadth of experience as a nutritionist and nursery-school consultant on the staff of the Elizabeth McCormick Memorial Fund.

The appendix contains a limited number of favorite recipes and is followed by a brief and pertinent bibliography.

Although this material is designed particularly to help untrained and inexperienced staff, it should prove a helpful handbook for all concerned with planning and serving food in group-care centers.

Catherine M. Leamy

YOUR NEIGHBOR'S HEALTH IS YOUR BUSINESS. By Albert Q. Maisel. Public Affairs Pamphlet No. 180. Public Affairs Committee, Inc., 22 East Thirty-eighth Street, New York 16, N. Y. 1952. 31 pp. 25 cents.

Graphic examples are given in this pamphlet of some of the things a health department does.

The booklet makes specific suggestions on how a citizen can find out how adequate the public health services are in his own community and how to work for improvements that may be needed.

• CALENDAR

Nov. 6. Play Schools Association. Annual meeting. New York, N. Y.

Nov. 7-11. National Conference of Christians and Jews. Annual meeting. Washington, D. C.

Nov. 9-15. American Education Week. Thirty-second annual observance. Information from National Education Association, 1201 Sixteenth Street, N. W., Washington 6, D. C.

Nov. 12-14. National Association of Intergroup Relations Officials. Sixth annual meeting. Washington, D. C.

Nov. 12-14. American School Food Service Association. Annual meeting. Los Angeles, Calif.

Nov. 12-15. National Association for Nursery Education. National conference. Minneapolis, Minn.

Nov. 12-Dec. 10. United Nations Educational, Scientific, and Cultural Organization (UNESCO). Seventh session of the General Conference. Paris, France.

Nov. 13-14. National Social Welfare Assembly. Seventh annual meeting. New York, N. Y.

Nov. 13-15. Family Service Association of America. Biennial meeting. Buffalo, N. Y.

Nov. 16-22. Book Week. Thirty-fourth annual celebration. Information from Children's Book Council, 50 West Fifty-third Street, New York 19, N. Y.

Nov. 17-19. National Association for Mental Health. Annual meeting. New York, N. Y.

Nov. 20-22. American Speech and Hearing Association. Twenty-eighth annual meeting. Detroit, Mich.

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THE CHILD

DECEMBER 1952



JUVENILE DELINQUENCY

WHAT DO WE WANT FOR OUR DELINQUENT CHILDREN?

WHEN A CHILD gets in trouble with the law, unless there are services available in the community to help that child find his way back to normal and healthy development, he is apt to take just the opposite road and end up in a career of crime. More than half of our adult criminals were juvenile delinquents.

Then, you may ask, why don't we have the community services to prevent the development of these behavior problems and to keep delinquent children from going from bad to worse?

One of the principal reasons why we don't have adequate services for the care and treatment of delinquent children is that there has not been a sufficient understanding on the part of the public of why they are necessary, what kind of services they should be, and what it means to a child to be treated as if he were a criminal.

Because of lack of public understanding, there has been a lack of public support for the quality and quantity of services these children need.

A good effort has been written in the effort to let the public about these services but sometimes this material is so complex and difficult to visualize. Many of us have to see things as we can believe them or not.

C
sis
agr

spect to the total problem of how juvenile delinquents are made will not be overcome by talk of prevention. Sometimes the end result of a disease or social ill must be studied and the costs to society dramatized before firm steps to prevention can be taken with public support. Then, too, children who are sick cannot be left to suffer.

If we were to raise the quality of practices in our handling of juvenile delinquents up to the level of the best jobs being done here and there over the country, I am convinced we would give many delinquent boys and girls a much greater chance than they now have to find a satisfying and useful role in society.

There is a practical program of action we can take to improve our treatment of juvenile delinquents. It calls, first, for over-all planning by States and communities to explore conditions, develop a blueprint of objectives, and work particularly on:

1. Aiding the police in developing special services for children;
 2. Getting juveniles out of jail and providing proper detention facilities;
 3. Providing the courts with adequate probation officers;
 4. Providing training schools to get personnel and additional facilities.
- ... ahead in these directions ... single public agency in ... with clear responsibility

for insuring teamwork amongst the various services for delinquent children and sound relationships between these services and child-welfare services for all children. Each State will want to work out its own kind of State-wide organization. Training of personnel, too, must be stepped up, and there must be more adequate financing of public services for delinquent children.

Through its newly organized Juvenile Delinquency Branch and the Special Juvenile Delinquency Project which is working closely with the Bureau, citizens and agencies will get increased help so they can move ahead on programs of improvement.

Every reader of this issue of *The Child* can help greatly in this effort, even if it is no more than by spreading "the news." Will you, as a first step, get this issue to the attention of 10 people in your community? Perhaps you can make this issue the focus of discussion at a coming meeting of one of the organizations in which you are active.

The Children's Bureau wants to keep in touch with every group that joins in this campaign. So when your organization gets going, won't you drop us a line?

M Martha M. Eliot
MARTHA M. ELIOT, M.D.,
Chief, Children's Bureau

EYEWITNESSES TO THE TOLL OF DELINQUENCY

A juvenile-court judge, the director of a detention home, a police chief, the superintendent of a training school—four men whose everyday concern is the prevention or treatment of juvenile delinquency—tell about their experiences in this work and of the problems they face

JUVENILE COURT

LEO B. BLESSING

Judge of the Juvenile Court, Parish of Orleans, New Orleans, La.

IF ENOUGH SPACE were available, I could list many problems and many unmet needs of our juvenile court in New Orleans, and they would undoubtedly be those of every juvenile court in the Nation. I know of none completely satisfied with its situation.

Some of our needs are so pressing, the function of the court as an agency for good in the community is vitally affected.

For example, at the present time we are unable to plan intelligently for the detention of children who are awaiting the court's decision as to what should be done with them. This period of detention can be a new and shaking experience for a child. We should try to profit from every moment of it in our treatment program.

But our present detention-care arrangement is makeshift and unsatisfactory. We are using quarters in other institutions, to the detriment of the care of their regular inmates, and sometimes we are forced to detain obstreperous juveniles in the parish jail.

The absence of a treatment center for disturbed juveniles is sorely and frequently felt. Yet there is not even a faint stirring of recognition of this need by the community.

Our case loads have grown considerably in recent times. This is

more the result of increased service potential than of increased delinquency. We are being called on more than ever before by other social agencies to help solve their problems, and parents are now voluntarily coming to us with their children who chronically misbehave. We welcome this confidence, but it often taxes our court facilities beyond their capacity.

Another problem is the legal segregation of races in our State. This

makes it necessary for us to supply separate accommodations and facilities for Negro and white delinquents. There is at present only one State institution for white boys and girls, only one State institution for Negro boys, and no public institution of any kind for the care of delinquent Negro girls.

Community understanding most important

However, the greatest problem facing the New Orleans Juvenile Court and, for that matter, every juvenile court, I believe, is failure to receive complete and wholehearted acceptance by the community it is intended to serve. It may seem strange and perhaps even absurd that a community should have to be urged to accept one of its own creatures—a crea-

The informal procedure used in this juvenile court helps to make the young delinquent feel relaxed and makes it easier for the judge to work effectively with him. The judge relies heavily on the skilled services of the trained probation officer who is attached to his court.



ture submissive to its will and completely at its mercy. But too often juvenile courts are simply poor little Cinderellas without the protection of a fairy godmother.

As it exists in the laws of most States, the juvenile court is a social agency within the framework of the law. It is the hybrid result of tempering the law's sternness with mercy and understanding.

In the chain of events that makes up the life of a delinquent child, being brought before the juvenile court is but a single link. However, it is an important link.

I know parents who search about for the best possible schools and teachers for their children. They buy the best clothes and most wholesome food obtainable. When sickness occurs, they insist on only the best pediatrician to attend their children. But they pay little attention to their juvenile court. At every available opportunity I ask these parents: "Why do you not insist on the maintenance of a good juvenile court for children for whom you want the best of every other kind of care? Why, indeed, this neglect of the juvenile court?"

A great deterrent to community understanding and acceptance of the juvenile court is the fact that the more active and prosperous elements in the population have little contact with the court. The majority of our children come from a level of society that has no voice and no weight in community affairs. Many of their families are so entirely engaged in eking out an existence that they cannot take time to champion the cause of community agencies even when such agencies affect the futures of their own children.

The vocal group in community affairs usually take little interest in the court because they do not expect to use its facilities.

Fortunately, not all children come to the juvenile court, but any child within the juvenile-court age limit might get into trouble with the law so long as he is forced to live in the artificial, accelerated economic environment of our typical urban com-

munities. And every child remains a potential victim of delinquency so long as our social services are inadequate to check the delinquency that exists in a community.

Perhaps the best way to create a sense of community responsibility for these services is to help the citizens of our communities understand the importance of juvenile delinquency: how it springs from basic unhealthy conditions in the life of a community, and how, unless checked, it can spread.

Not many people would be willing to gamble their whole life earnings on the flip of a card, but many communities are taking just as great a chance when they permit the whole future lives of many of their children to be decided by a poorly trained, inadequately staffed, and weakly led juvenile court.

If we can arouse the individual members of a community to an understanding of their responsibilities for the proper development of their juvenile court, we shall then be guaranteed an adequate court and all the necessary outside facilities for carrying out a successful treatment plan.

Expanded New Orleans needs expanded services

In New Orleans, where the population had been more or less static at the half-million mark for many years (due in part to expansion-limiting water boundaries and in part to a lack of aggressive planning), the juvenile court was for a long time shamefully neglected by the com-

munity and was let stagnate in hopelessness and frustration. But the fight we have made for our court during the past 4 years has brought us recognition and is beginning to return dividends.

We have won an increased appropriation, a trained probation staff (though it is still too small), and construction of physical quarters that have added much to effective work and judicial dignity and have been helpful in gaining additional community recognition and support.

But the fight is not finished. It is never-ending, for a good juvenile court must be progressive, flexible in program, and far-seeing. Already we are planning for our future needs—a program that will "sell" the community on the value of the juvenile court and the need to protect our children. With reclaimed swamplands now available for industrial development and because of the courageous leadership of our mayor, New Orleans has expanded considerably within a few years' time, but our court has failed to expand in keeping with this increase in population, interest, and problems. We are already alarmingly understaffed. The court's services are being taxed beyond their capacity, and we should be expanding and planning for additional community service. This is our most immediate problem, and we shall continue with courage and persistence to seek complete community acceptance as a major step toward its solution.

DETENTION

STEPHAN H. KNEISEL

Executive Director of the Essex County Parental School, Newark, N. J.

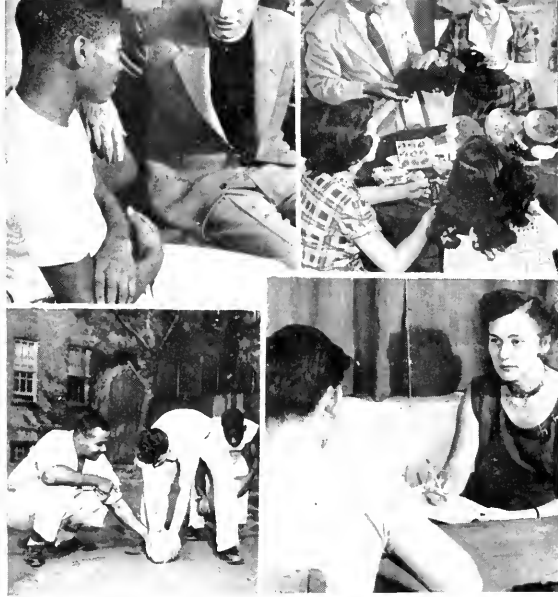
THE COMMENT I've been hearing for 25 years, that "Everybody talks about juvenile delinquency, but nobody does anything about it," does have some truth in it. I believe the truth of the statement arises largely from the fact that this social ill has not been given the same

amount of attention and focus that has been given such hazards to children as infantile paralysis, tuberculosis, and various physical handicaps. It is therefore encouraging to have a special juvenile-delinquency project of Nation-wide scope.

I work in a home that provides tem-



In some communities delinquents who require temporary detention, pending court hearing, are held in jail—often with criminals. This kind of detention care offers nothing in the way of rehabilitation.



Detention can be a constructive experience. In this home young delinquents follow a varied program. They are offered individual counseling, and their educational and recreational needs are taken care of.

porary detention for delinquent children. This is a highly specialized child-care service, little known and less understood by the community, and only recently emerging from a jail philosophy to that of social treatment of the emotionally ill offender. My primary concern in this article will be to comment on the problems of temporary detention, but I should like to point out that these observations will take into account other problems in this field that I have met with during 25 years' experience working with children in trouble. [Mr. Kneisel has been a school teacher, a parole officer, a social worker in a court psychiatric clinic, an administrator of day-care and nursery-school programs, the director of a council of social agencies, and during the past 8 years the administrator of juvenile-detention facilities in three areas of two States.—ED.]

Consistent with the recent reports on national statistics, the rate of commitments to our little detention facility in 1951 showed a 20-percent increase. If our experience for the first 6 months of this year continues, 1952 will show a substantial increase in de-

linquency over the previous year. In fact, during the month of May we were at an all-time high in the rate of daily admissions, exceeded only by the first day of June, when 18 children were admitted in one day. The impact of an additional 18 children in a home that is meant to accommodate 50 can well be imagined, particularly when the rate of intake for the previous week had been almost as high. We were sending our overflow to the adult house of detention. We simply did not have the bed space.

Architect's plans for a more adequate juvenile-detention facility—to accommodate 80 children—are presently before county officials. We hope for final approval before long. But if the rate of intake continues to increase, we may find that at peak periods we'll have to continue to use the adult facilities.

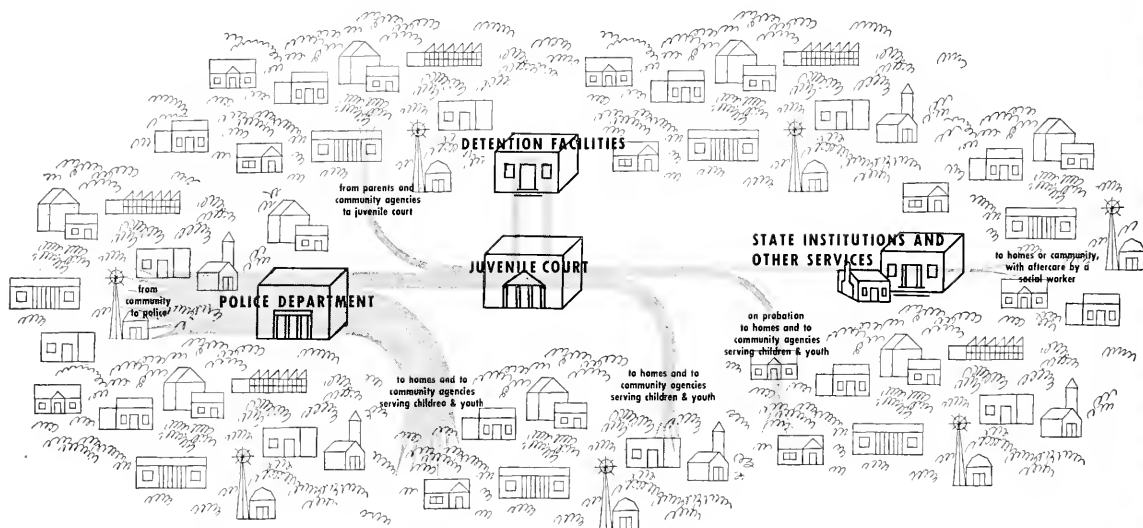
We get children who should not be here

We in children's work have long been aware of the trauma involved in separating a child from his home for foster-home placement. Much time is therefore devoted to preparing the child for the separation and place-

ment. And we recognize and accept that, despite our best efforts, there will still be deep disturbance. Yet, to my knowledge, throughout the years there has been little awareness of our concern for the deep trauma that results from forced separation and placement in a detention facility, an experience that sometimes drives children to emotional outbursts bordering on the psychotic, or even to attempts at suicide. The community and its agencies have not yet begun to understand fully the injustices ignorantly committed against children in this way.

For this reason I urge that detention be used only when it has been determined by competent authority that no other resource exists in the community to provide temporary care for the child and that it is in the best interest of the child and of the community for him to be detained. The role of the detention facility should be limited to the detention and care of children who are too unstable and ill emotionally to be permitted to remain at large in the community. It should be the first step in an expeditious and integrated treatment process.

Children in trouble with the law—where they come from and where they go



The detention facility should cease to be a juvenile jail. Too often it functions as the "back room" of the police station; or as the temporary "dumping ground" for agencies too understaffed to follow through in planning for the return of a child to his own home or to a foster home; or as the agent to serve the personal vindictiveness and animosity of a particular official toward a particular child.

Detention care should be temporary

Despite our best efforts some children are held in detention far too long. I make this observation without prejudice to my present facility, for it pertains as well to institutions I previously served, and, in fact, it constitutes one of the gravest concerns of most administrators of temporary detention facilities. Along with the recent increased rate of placement in my present facility, the number of days of care would have increased correspondingly but for the consistent effort on the part of the juvenile court and other local agencies to support the intent of temporary deten-

tion by keeping the length of stay at a minimum. Consequently, although intake went up, the average length of stay dropped from 11 days to 10.

It is understood that the court should know something about a child before making a final disposition. The information required may vary from a social study to the result of psychiatric observation and diagnosis. However, although we have come to accept the need for knowing something of the child, we have not yet begun to meet the need to do it expeditiously, if the child in detention is to be constructively served.

Few communities are equipped to undertake such studies expeditiously, and weeks can run into months before studies are completed and a court disposition is made. Meanwhile the child in detention lives in a purgatory of anxiety, despite the best efforts of skilled workers and the best of physical facilities.

As with my first institution, my present institution is in a community whose child-serving resources are probably at least equal to those of most communities, yet both com-

munities lack a psychiatric hospital to which emotionally disturbed children may be referred on an immediate and emergency basis for study and observation. One institution with which I once worked had the advantage of the services of a children's pavilion in a psychiatric hospital. I had forgotten how desperately such a resource is needed until I came to my present institution and found that no such service existed.

Treatment resources vitally important

Once a diagnosis has been made and a treatment plan determined, the child should be moved to the treatment facility promptly. There can be no justification for continuing a child in temporary detention for weeks and months once a plan has been made.

The result of study may indicate that the kind of service needed by a child is that provided by a foster home. In court the child may be told that he will be placed in such a home, rather than being sent to an institution. The immediate reaction of the child is apt to be joy and new trust in the sincerity of the adult world.

But as week follows dreary week and no foster home is forthcoming, the child's mood turns to bitterness and defiance. If a foster home is finally located, is it any wonder that the child no longer responds? Often the home is *not* found and, after weeks of waiting, the child is simply sent to the State school.

If a foster home is not to be used, the study may indicate that intensive psychiatric treatment is needed—either in an institution or in the community. Again the question is: Where can such service be found? Treatment institutions for older children are so rare that even where they exist they constitute demonstration projects rather than community resources.

The present dearth of treatment facilities in all communities too often results in ultimate commitment to that catch-all, the State school, which most often is not staffed to give psychiatric treatment. If State schools are to continue to be the major resource for the long-term detention of children with serious character and behavior disorders, steps must be taken to make it possible for these institutions to offer the treatment and care necessary for the children committed to their care.

I know of no community—city,

county, State—that is providing the varied and integrated services necessary for the differential treatment of the various types of behavior we lump under the head of "juvenile delinquency." This is a blanket term without much meaning—much like the word "sickness." We have come to understand that though infantile paralysis is a sickness, it is different from tuberculosis both in symptoms and in treatment. And we accept the fact that although infantile paralysis, tuberculosis, and other diseases are all "sicknesses," each has to be

treated differently, and that treatment is difficult and expensive. But we seem not to have accepted the same inevitable conclusion for juvenile delinquency.

The primary answer to the problem of the prevention and proper treatment of delinquent behavior is, I feel, the gaining of an enlightened and enthusiastic public understanding and support of the kinds of programs and services that are so vitally needed by those children who, because of their behavior, are termed juvenile delinquents.

POLICE

L. D. MORRISON

Chief of Police, Houston, Tex.

THE RESPONSIBILITY of the Police Department to help prevent juvenile delinquency and crime flows naturally from its fundamental obligation to protect the people and property of the entire community.

Police administrators have recognized their grave responsibility, and, as a result, many of them have established a special unit or division with-

in their departments to meet the needs of those children in the community who come to their attention because of misbehavior.

Here in Houston we established such a division many years ago. It is called the Crime Prevention Division. Through this division we attempt to carry out our responsibility for delinquency control in a growing metropolis.

In your community, when a child is picked up by a policeman for misbehavior, is he handled just as though he were an adult criminal?

The juvenile-aid policeman who is taking this delinquent boy to a detention home has been trained to work constructively with children.





A prison-like atmosphere in an institution makes it hard for the staff to win the boys' cooperation. They are apt to feel like criminals.



A pleasant and homelike air about a training school helps the boys to feel that they are there to be rehabilitated rather than punished.

It is hardly necessary to say how valuable such a division is. Children are the community's most precious asset, and it is worth our every effort to help prevent future criminal careers.

Police officers must always be aware of the fact that a young person's entire future may depend upon his first contact with law-enforcing officers. If a child is treated firmly, but with kindness and understanding, much can be accomplished toward making a good future citizen out of a potential threat to society.

Advances made with difficulty

We are vitally conscious of our failings and of our difficulties. Dealing with children has made us feel a special need for perfectionism, and we make an all-out endeavor in our work with them.

We make every effort, therefore, to select carefully the personnel who staff our Crime Prevention Division. In the not-too-dim past, assignment to the juvenile division was literally banishment to isolation. The most inept officers were to be found in most police juvenile agencies, working half-heartedly and without enthusiasm.

Today, because of the influx of young, well-trained, and energetic officers into the police field, the picture is more encouraging. No longer is assignment to the Crime Prevention Division considered a casting away of the officers, but is a choice and favorable experience.

We have been most fortunate in having what we consider the most modern police administration building in the South. A generous citizenry has spared no expense in building and equipping a modern workshop for police activities. Consequently we have been able to provide more than adequate facilities to house a growing Crime Prevention Division. Occupying a complete wing, the Division is able to carry out its function in almost total separation from the adult divisions. This healthful atmosphere affords us a greater opportunity to remove the damaging stigma of police procedure from the child's experience in the police building.

It is imperative that we work in close harmony with the many public and private agencies that are concerned with the welfare of children. We want community agencies to feel

free to use juvenile-police services. The juvenile-aid officer must, to discharge his duties properly, refer many children to these agencies. Unless they understand our function as a discovery and referral agency, and unless we know about their facilities, the efforts of both would be for naught. For that reason, we are invited to participate in the round-table planning of the Council of Social Agencies and of the Community Council.

Some children, of course, cannot be referred by police officers to community agencies, but must be taken to the juvenile court. Naturally the Crime Prevention Division officers give wholehearted support to efforts to improve the official public services for adjudged delinquents.

In reviewing our Texas procedure we learned that about one-half of our boys and girls who are adjudged delinquent are, in later life, committed to adult prisons. This indictment of our procedure led to the creation of the Texas Youth Development Council, a new and revolutionary scheme, which promises to be one of the Nation's most workable plans for rehabilitating delinquent children.

Narcotics and wild drivers

Much concern has been exhibited in our community in recent times over the use of narcotics by our teenagers. Certainly a southern city such as ours—a focal point for narcotic traffic northward—might be a most fertile ground for inducing youth to become addicted. But our experience indicates that the extent of this problem has been greatly exaggerated. Records reveal that few of our children of school age have been dealt with for contact with narcotics. In the few cases in which this has happened, the boy or girl was one who had been involved in many other delinquent acts, and contact with narcotics was only one facet in the delinquency pattern. We have found no cases where a child who was not already delinquent has been introduced to the use of narcotics.

Larger cities in Texas have found juvenile traffic violation to be something of a problem. The machine age presents juvenile law-enforcement agencies with one type of offense for

which a satisfactory disposition remains to be found.

At present, a statute is available—though its worth is questioned by many—for Texas officers seeking answers to the juvenile traffic problem. This statute provides that juvenile traffic offenders found guilty of driving intoxicated, recklessly, or above the maximum speed limit are subject to penalties similar to those that may be imposed on adults for the same offenses. The suspended sentence under this statute, used most widely in rural counties, has been found effective.

We still have a long way to go. But our experience so far has convinced us that the police must function as a working cog in the community effort to control delinquency. Care must be exercised to select proper personnel, and great attention must be given to community conditions that might lead to delinquency.

With a young police department, such as ours, much can be accomplished toward effective crime prevention.

ago we had as few as 30 employees to control 300 or more boys. As recently as the early 1940's college graduates on the staff were earning as little as \$50 a month, with other personnel many times receiving less, for long hours of work. Today we can talk of "treatment" and "training," but we must remember that our advances have been made by a slow and tortuous process. It has been through the errors and sacrifices of our forerunners that we have reached our present "state of grace."

In some respects the reputation handed down to us from the past continues to hinder our work today. Each month we receive children whose older brothers, cousins, or fathers even were once institutionalized here. The stories that they have heard from these relatives have definitely made these children afraid of the institution. Sometimes it takes months for us to succeed in overcoming their fears. Meanwhile, they have related the Village's past history to others.

Background of deprivation

A great deal of water has passed over the dam of our boys' lives before they come to us. Chances are they either were born out of wedlock or cannot remember a real father residing in their homes. Their mothers frequently were at the doll-playing age when they became pregnant. At present we have one 14-year-old youth whose mother is but 25 years old. Another of our youths is the result of a young girl's being raped at the age of 14. At 15 she died from tuberculosis, and this boy was hospitalized 5 years for the same disease before he came to us as physically cured.

Our "average youth" is about 15 years old, with a mother in her early 30's. The child was reared usually by a grandmother or by some other elderly relative who neither understood nor wanted him. Often he has lived in a series of foster homes, placed there because of family neglect. In a majority of instances his family has lived in a well-known slum area, in a marginal dwelling, and has received public relief grants.

TRAINING SCHOOL

LAWSON J. VENNEY

Superintendent of Boys' Village of Maryland, Cheltenham, Md.

BOYS' VILLAGE of Maryland, an 80-year-old institution, is in many respects a typical training school. We have had our due proportion of failure and success. Some of the youths who were once here have since become involved in additional delinquencies—and have made headlines. But it is difficult to find stories about our successes. Although many juvenile courts and other agencies furnishing aftercare service for us do report that we have been successful in our planning for disturbed children, this information does not make "good copy" and receives little of the attention given our failures.

The Village was not founded yesterday; it has to live with its past. Local newspaper morgues are full of stories about its past brutality toward children. The fact that brutality was practiced cannot be denied. Many training schools have dungeon relics. Our old records show that, as punishment for running away or fighting, young boys were confined in these dungeons for as long as 30 days, with a restricted diet and after being lashed. But these methods of control have not been used at Boys' Village for many years.

Our progress on other fronts has been somewhat slower. Not too long

Record after record shows that his schooling did not start until after his seventh year. Even then he was out of school as often as he attended, at first because of lack of shoes, or too great distance from home, or some such reason; later because remaining away from class became the easiest way to meet his failure to achieve.

The pattern after that is often the same. Roaming the streets is no fun without money to spend, and begging for pennies not too successful after a child passes the "little" stage. As one boy told me: "As long as I was small and cute, people gave me money. After that stopped I began shoplifting."

Delinquents are early truants

On a recent visit to the Village by a group of public-school administrators from a city that sends us 65 percent of our students, these school officials expressed their amazement at the number of boys they could call by name. They told stories of how aggressive some of these children were toward their teachers—even to the extent of fighting them. Many boys were pointed out as gang leaders, who forced smaller and weaker children to give them money. Others were said to have maliciously destroyed school property.

These public-school administrators all agreed on one point in particular, namely, that the children here whom they knew had all been persistent truants from school. During the past few years, as I have talked with institutional officials in the United States and from foreign countries, this basic fact has been repeated many times: The children sent to training schools have been well-known truants who disliked and refused to attend school classes. One principal said: "Those of your children known to me were spotted years ago by teachers who could easily have predicted their commitment here."

The typical Boys' Village youth has an I. Q. in the 80's. After a series of school failures, usually because of poor attendance, he may have reached the sixth grade at the time of his

commitment. The results of the educational and psychological tests given by the Village personnel show that he is 4 to 5 years behind in his school work. Very frequently he is a non-reader and is unable to do classroom work in a level higher than the fourth grade.

After they are released, 50 percent of our youths 16 years or older never return to school. Why should they? As they ask, "Who wants to sit in classes with junior high kids and not understand what they are doing?" If they were placed at the level where they should be, they would be "twice as large" as the other children in the class.

Some people call these children "misfits." Actually, they are children for whom society has failed to plan adequately. Thrust out into a competitive society that expects a dollar's work for a dollar's pay, they again find it difficult to achieve their balance. Even when there are jobs available for teen-agers, the competition from children who are products of intact homes is too great.

Recently I interviewed one of our boys, a 16-year-old who had run through four jobs in 6 months' time. His story was typical of many I have heard:

"There is no one home to get me up My mother never gives me any breakfast I didn't have lunch money for 8 days. When I walked home there was nothing to eat, and the boss fired me for taking too much time off for lunch."

This youngster had tried to walk to and from home for lunch—a total distance of 6 miles—in one hour's time!

One 16-year-old boy who was with us for 3 years returned to visit us last week in a *stolen car*. We learned that he could not find a job and his mother was tired of feeding him. She had told him to move in around the corner with a 17-year-old girl friend who worked.

Another recently released 16-year-old who had made a very successful adjustment here, begged the courts to let him return. In making room

for him at home, his mother had forced her boy friend to move out. However, she only accepted the boy as a "duty," and constantly irritated him by relating how much money her friend had given her. It is little wonder that the boy became involved in further trouble within 3 months of his release from training school.

Careful planning needed

Training-school employees have a tremendous responsibility. They receive for treatment children who are usually unwanted and often unloved. Within a short span of time—the average length of stay at Boys' Village is 11 months—and assuming that there has been proper diagnosis and a good treatment plan, the training-school personnel must gain acceptance of children who have learned to distrust adults.

Institutions can be havens of refuge for those children who need planned group-living experience. The smaller and less complicated the school, the easier it is for every employee to know the total child. And the better the State classification procedure, the less often will feeble-minded children be found housed with aggressive delinquents, and sex deviants with healthy youngsters who are just beginning to ask questions about life.

There are answers to the many problems involved in planning for institutionalized children, though they may not be easy to find. Citizens must be alerted and officials and legislators intelligently "sold" on the need for services. One man or woman in each State can do this. But he will need the humility and tenacity of purpose of a Ghandi, the firmness of St. Peter, the wisdom of Solomon. In a sense, citizens who seek to give children the chance for a fuller and happier life must be dedicated in their mission. They must believe in the democratic way of life. And they must recognize our children as America's richest heritage.

FOCUS ON DELINQUENCY

BERTRAM M. BECK

JUST A FEW months ago representatives of about two dozen major national voluntary organizations concerned with the welfare of children sat down to discuss the recent rise in delinquency. The group was struck by the fact that although practically all of them saw their activity as at least in part contributing to the prevention of delinquency, only a few had any specific program for delinquent children. This was perhaps no more than to be expected.

In the past we have quite properly held the view that prevention of delinquency, rather than treatment, is our major goal. We have been reluctant to talk of a program that offers treatment to the juvenile delinquent, holding that such a concept has little meaning and that what we do in the interest of children should be accomplished for all children, not for just one category.

The recent steady rise in delinquency, however, gives cause for a careful examination of some of our ideas about delinquency. We have come to the point where we must face certain questions squarely: Do delinquent children have characteristics that are different from those of other children served by our public and private child-welfare program? If so, what are they? And if there are such differences, what implications do they have for our programs in the prevention and treatment of juvenile delinquency?

In answer to these questions, there is reason to believe that finally, though perhaps reluctantly, we are commencing to accept the fact that delinquent children *can be distinguished* from other children and that their distinguishing characteristics *have definite implications* for treatment.

Two ways in which these children are distinguished will be discussed

here. In one case the characteristic arises purely from their situation. The simple fact that a child comes before the court as a delinquent and is involved in a legal process sets him off from other children. The authoritative setting cannot fail to have considerable significance in the way in which delinquent children respond to treatment. This fact has long been understood, but we have failed to accord it sufficient recognition, particularly in the training of personnel.

The second distinguishing characteristic is more limited but is of no less importance. It is the temperament of a certain kind of delinquent child within the larger group of delinquents, both adjudicated and non-adjudicated. This child is one of the "chronic delinquents," who make up the "hard core" of the delinquency problem. New research has shed a brighter light on this group of children.

Let us look at the more general characteristic first.

I

Authority pervades the life of the delinquent child so long as he remains within the pale of legal supervision. And although the juvenile court acts in the interest of all children who come before it, there is a marked difference between the reason why a delinquent child is brought to court and the reason why a neglected or dependent child appears before the court.

The neglected or dependent child is brought before the court because of events outside his control, the delinquent child because of his own delinquent act or acts. The delinquent

child may, and often does, view his court experience as punishment for misbehavior. The public more or less sees the delinquent child as a threat to public safety, and as an offender rather than as a child offended against.

In other words, once a child becomes the official concern of the juvenile court because of an act of delinquency, his court experience has an effect both on him and on the public's attitude toward him.

Here, then, is one considerable difference between children coming to the attention of the court because of delinquency and children of comparable age who are the concern of the court or of public and private child-welfare services for other reasons. This difference must be taken into account in the treatment program for all delinquents who come before the juvenile court.

"Treatment" may seem like punishment

Whatever the juvenile court does to alter the course of life of a delinquent child is likely to be seen by that child as punishment for his misconduct. This fancied or real punishment may aggravate the hostility of a child and perhaps induce other rebellious acts. Thus, the treatment may aggravate the disease.

The delinquent's distrust and rebellion against authority commence at an early age. The case records of delinquent children tell us that the large majority were truants from school.

It is interesting in this regard to look at an account of the appearance of two ex-delinquents before a meeting of the National Conference of Juvenile Agencies.

In response to the question from the floor, "What was the first institution that you ever went to?" one of the boys named the public school he had attended!

These two boys found absolutely nothing good to say of the various

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institutions they had been in. So far as they were concerned, they were *made* to do things and when they failed to do them, they were *punished*. They said they could understand being "knocked off" for doing something wrong but it seemed to them that they were always being "knocked off"—and without any apparent reason. In other words, to those two boys, treatment was punishment.

In summing up their opinion about institutions, the boys had this to say: "There ain't no such thing as a good joint—and there never will be. A good joint is no joint."

Implications for treatment

The statements of these two boys highlight the very difficult problems of those workers who are engaged in programs for the "officially" delinquent child.

The police officer who apprehends such children, the juvenile-court judge, the probation officer, the staff of the detention home, and the staff of the training school—all need special skill and knowledge to deal with these children. All must have an acute awareness of the need to protect public safety and the civil rights of parents and children. All must exercise authority vested in them by law. All must function in such a way, however, that the child is not embittered and the delinquency is not aggravated.

The police have a major role in delinquency control. They bring a ma-

jority of delinquents to the court. At least one million children come to their attention each year because of some alleged act of delinquency. Many of these children are not taken to court. The police officer must decide in each instance what action he will take.

Recent years have witnessed a rapid expansion of special branches of police forces for work with juveniles. Many police forces have developed services for children that seem more appropriately the job of the social agency. According to police authorities, however, such services have been developed simply because of the reluctance of existing social agencies to adapt their programs to meet the need of the delinquent child.

Those social agencies that work with delinquent children must develop sympathetic and cooperative relations with the police. They must learn to appreciate the difficult role of the police, who have the dual task of protecting public safety and, at the same time, serving the broader interests of the child and the community. They must aid the police by accepting such responsibility for the treatment of delinquency as is rightfully that of the social agency, and by supporting necessary measures to promote special training for juvenile police officers.

The part that the **juvenile court** plays in a program for helping delinquent children is crucial. The juvenile-court judge must have legal

skill and also the ability to use the knowledge both of the social workers who serve him as probation officers and of other such specialists.

In some instances the judge's opinion as to what might be best for the delinquent child has to be tempered by other considerations. For example, a boy who sets fires may have to be committed to an institution even though he might better be given psychological treatment while remaining in his own home. In other words, when a delinquent constitutes a real and immediate danger to other persons, the necessity to protect public safety will undoubtedly influence treatment plans for this child.

As another example, community sentiment in regard to certain sex offenses may necessitate removal of a child from the community in contradiction to his best interest. The juvenile-court judge must know how to strike a balance between the interest of the delinquent child and the protection of the public safety. Such considerations usually do not enter into his work with dependent and neglected children.

Another primary consideration that must invariably determine the opinion of the judge is respect for the civil rights of children and their parents. These rights must be protected. The fact that a child has committed certain acts must be well established before a court can take action in the interest of the child. No attempt should be made to "stretch the law" so that a child who cannot properly be considered delinquent under the laws of a State is adjudicated delinquent merely to make it possible for him to receive services. The maintenance of the proper legal process in protection of the rights of man takes precedence over procuring services for an individual child.

The role of the **probation officer** is particularly difficult. Not only must he be guided by the same consideration that affects the court but also he must undertake treatment that will best help the child. The child on probation may, if he fails to make adjustment, be returned to

Friendly, skilled counsel gains trust and often brings a desire to be better. Improved training for personnel who work with children is probably the delinquency field's greatest need.



that court and possibly sent to an institution—a possibility that represents the extreme in punishment to most delinquent children. The probation worker becomes for the child the symbol of the authority against which he rebels.

The probation worker must therefore attempt to convert what appears to be a handicap into an asset. He must not surrender his authority, but he must exercise it on behalf of the child and the general public. With skillful handling by the probation officer, it is hoped that the child comes finally to accept his guidance and counsel. And as the child learns to accept reasonable authority, he learns also to accept the authority exercised in the outside adult world.

Although probation services are offered by the child-welfare worker in many jurisdictions, the authority role remains the same. The worker needs special skill and knowledge over and above what is required for serving children in nonauthoritative settings.

Discussion of the role played by the staff of the training school might best perhaps be included in our discussion of the second major distinguishing characteristic of delinquent children. For usually it becomes the responsibility of the training school to treat the "hard core" group of delinquents, about whom we are now going to talk.

II

Within the group of adjudicated delinquents dealt with in the juvenile court, there is a smaller group of chronic delinquents. These children are different from other groups of delinquents, and treatment must be planned for them in the light of their special characteristics.

Their differences have recently been brought out more clearly as the result of a study by Sheldon and Eleanor Glueck. In this study 500 delinquents in a training school were compared with 500 nondelinquents of similar background and characteristics. All the children were boys, and all lived in underprivileged neighborhoods. In each pair, the delinquent and the nondelinquent were of simi-



Will these children become delinquent? Well-planned community services can prevent this.

lar age, intelligence, and national origin.

The most important distinguishing characteristic between the groups of children was that the delinquent children did not have the ability to control their rebellious, aggressive, hostile feelings, and gave vent to such feelings in antisocial acts.

The nondelinquent children, on the other hand, either had some kind of safety valve, so that they could deal with their hostile impulses without conflict with the law, or they held their hostility inside them, where it contributed to a feeling of discomfort but was not of immediate concern to those around them. Anyone who has restrained an impulse to "tell somebody off" and then has developed a "nervous headache" or upset stomach can understand the plight of such nondelinquent children.

The nondelinquents, to a far greater extent than the institutionalized delinquents, had internalized emotional disturbances. The delinquents were free-wheelers—adventuresome, restless, impulsive, and destructive, but relatively free from worries and anxieties until the community interfered with their behavior pattern. The nondelinquent group contained by far the larger proportion of the "worried" children.

What makes them delinquent?

All the children the Gluecks studied were children of the slums. Sociologists, led by Clifford Shaw, have pointed out how most adjudged delinquents come from the disadvantaged areas of a city. Allison Davis, a prominent educator, has deepened our understanding of why so many delinquents come from slums. He showed us how difficult it is for all the people in a community to have a single idea of right and wrong when people of one race or people from one economic level are segregated in a particular section of a city. The youngster brought up on the "wrong side of the tracks," where the fight for survival is bitter, may in turn enter into battle with society in general. The child on the "right side of the tracks" usually adopts the conventional or conforming behavior of his elders.

All the children studied by the Gluecks were early in danger of becoming delinquent because of conditions in the neighborhood in which they lived. The delinquents, however, had an additional handicap not suffered by the nondelinquent. To a far greater extent than the nondelinquents, the chronic delinquents were reared in homes offering little affection, guidance, stability, or protection. Their parents, weighed down by

personal misery and poverty, were not able to offer that extra something that can keep a child even in the worst of slums from becoming delinquent.

Although most of the delinquent children studied did not come into court until early adolescence, about one-third were noticeably delinquent as early as 8 years of age.

Implications for prevention

Knowledge about this hard-core group of delinquent children now makes it possible for a community to attack the delinquency problem in a precise fashion—both from the preventive and treatment aspects.

Preventive activities can and should be part of a broad program designed to prevent all kinds of social maladjustment. Certain activities, however, can be aimed at a specific objective, namely, those children who are prone to delinquency but are not officially delinquent. This group includes the youngster who is just beginning to develop a pattern of delinquent behavior. Also included are the chronic delinquents who have been known to law-enforcement agencies in the past, and those chronic delinquents who through wit or luck have escaped official notice.

Our knowledge of the characteristics of the chronic delinquent, for example, demonstrates that even at an early age he probably cannot be reached by the conventional supervised recreation program. He is more often a child of the street. He represents the authority represented by supervision and he craves excitement and adventure. To reach these children, therefore, a recreation program must reach out to the delinquent child and his gang, and must operate in the child's own territory—the street. Such programs have been launched in several cities.

Furthermore, we know that if we wish to curtail the development of a delinquent pattern in a child opposed to school, we must utilize the best in modern educational techniques to hold the attention of that child.

The fact that the children in our training schools usually have an al-

legiance to gang activity makes it important that a preventive program in the community offer services to the gang as a unit.

In other words, if a community wants to reach the truly delinquent child, its program must reflect the definite knowledge that we have of the characteristics of this kind of child and not merely provide activity good for children in general.

In addition to programs aimed at children already involved in delinquency patterns, preventive programs must also be aimed at strengthening family living, so that problem behavior will not develop among the very young children. New light on the subject of delinquency makes it clear that if such broad programs of prevention are to be successful in curtailing delinquency, they must be aimed at the preschool child. Citizens, regardless of their walk in life, must band together to eliminate the areas that are the primary breeding places of delinquency. Basic social and economic measures are usually necessary. Parent education and guidance and counseling for children and parents should be provided in the community to aid parents in the rearing of healthy children. All that we now know about the prevention of behavior disorders underlines the need to aid parents with problems of child rearing during the earliest years of the child's life.

Implications for treatment

Knowledge of the special characteristics of the child whose delinquency pattern is well developed provides clues for the successful treatment of such children.

Social and psychological understanding is needed in order to comprehend the relationship of family and community in promoting delinquency. The treatment offered the chronic delinquent, however, probably must be something different from that offered the emotionally disturbed child.

Because of rejection by adults and substitution of the gang for the family, it may be that the chronic delinquent could be treated, at least in-

itally, in groups. Singly or in groups, the establishment of the relationship between the person doing the treating and the child being treated is of primary importance.

The major problem would seem to be that of helping the child develop necessary inner controls of behavior, rather than aiding him in the resolution of internal conflicts.

Herein lies the task of the staff of the training school in most instances.

Delinquent children have special needs

In summary we can therefore say that the delinquent child has, on the one hand, the same needs as all children and, on the other, special needs.

Just like other children who require attention from public or private social agencies, the delinquent child may need casework treatment, psychiatric treatment, or foster care—singly or in combination. Since such services are offered for all children who need them, they may be and often should be under the administrative auspices of a single agency. Services for certain groups of children, however, must be geared to the particular needs of those groups.

Infatuation with the concept that children are children, and that the word "delinquent" is a label without any particular significance, has impeded the development of necessary services for delinquent children. A great deal of attention has been given to activities for prevention. Such activities often march under the popular banner of delinquency prevention, but are, in reality, activities designed to make possible a healthy development of all children. It is very likely that these activities do prevent delinquency, as well as a host of other social disorders. Such prevention programs, however, will not cope with the chronic delinquent in the community, who needs preventive services specially adapted to his particular characteristics.

At the present time, services for delinquent children who come to the attention of our law-enforcement agencies are seriously limited.

(Continued on page 71)

A FEW FACTS ABOUT JUVENILE DELINQUENCY

OUR FACTS on juvenile delinquency are taken mainly from two sources: police fingerprint records, sent in to the FBI, and juvenile-court delinquency cases, reported to the Children's Bureau.

All these reports are sent in on a voluntary basis, and they give only uneven coverage. As a result, the data may not be representative of the national picture.

Limited as they are, however, these facts, combined with data from other sources, furnish the best available means for estimate.

It will be one of the aims of the Special Juvenile Delinquency Project to help secure more reliable data on juvenile delinquents, and thereby improve our methods of helping them.

HOW MANY DELINQUENTS?

In 1951, *an estimated 350,000 children* were brought to the attention of the juvenile courts in this country for delinquent behavior. The boys outnumbered the girls 4 to 1.

A much greater number, *perhaps a million or so*, came in contact with the police on account of misbehavior. This group included many who were referred to the court.

Many delinquent children escape the attention of the law. We do not know definitely the number of these "concealed" delinquents, but studies indicate that it may be considerable. A survey made in a large Eastern city of the case records of children coming to social-work agencies for help and guidance revealed that of the large number of children who spoke openly of the serious acts of delinquency they had committed, *almost one-third of the children were un-*

known to the police. It is impossible to estimate how many delinquent children escaped the attention of all agencies in the community.

IS THEIR NUMBER INCREASING?

The answer is *yes* if preliminary data for 1951 from juvenile courts reporting to the Children's Bureau is a reliable indication of what is happening. For these courts the number of child delinquents *increased 19 percent* between 1948 and 1951. Figures on police fingerprint records show a similar trend. The number of children in the country in the principal age group affected (10-17) increased only 5 percent during that year.

Unless we do something now to prevent it, there may be further increases in the number of delinquent children. The total number of children in the age group 10-17 is expected to increase 45 percent between 1950 and 1960.

The babies born during and after World War II are growing up. Will the number of delinquent children also increase 45 percent? Will it increase at an even greater rate, as it is now doing? Or will we succeed in preventing an increase?

WHAT HAVE THEY DONE?

Juvenile-court reports show that the majority of the boys are brought in for *stealing* or *committing malicious mischief*.

Most of the girl delinquents are brought in for *being ungovernable*, for *running away*, or for having committed a *sexual offense*.

Police fingerprint records reveal that in 1951 children under 18 com-

mitted *24 percent* of the Nation's *auto thefts*.

They also commit crimes of violence: *3 percent of homicide cases* and *7 percent of rape* in 1951.

More *serious crimes* were committed by boys and girls 18 years old during the first 6 months of 1952 than by persons of any other age group.

HOW OLD ARE THEY?

The majority of delinquent children who come before juvenile courts are *between 15 and 17* years of age.

Approximately *35 percent* of the delinquent children who come before the courts have been there on *one or more previous occasions*.

The age at which the largest number of delinquents are *first* apprehended by the police or referred to the court seems to be *between 13 and 15*, or approximately at puberty. This was shown by a study of a thousand delinquent children.

Nine-tenths of these same children were having considerable difficulty adjusting to normal life *before they were 11 years old*. *More than a third* of this total group of one thousand children were showing noticeable signs of *becoming delinquent* at the *age of 8 or younger*.

WHAT HAPPENS TO THEM?

Of the one million children who came to the attention of the police for misbehavior last year, about 750,000 were *dealt with directly by the police*, who let them go with a warning or perhaps referred them to a social agency for guidance and help.

The remaining 250,000 committed acts of delinquency so serious that the police *referred them to the juvenile court.*

An additional 100,000 were brought to juvenile courts by *parents, teachers, social agencies,* and the like.

At least 115,000 of the 350,000 children who were brought to the juvenile court were held overnight or longer in a *detention facility, police station house or jail.*

It has been estimated that from 50,000 to 100,000 children are *confined in jails each year* by the authority of the courts or other law-enforcement agencies.

Of the 350,000 delinquent children who came before the juvenile courts in 1951, the cases of about half were *dismissed, adjusted, or held open* without further action.

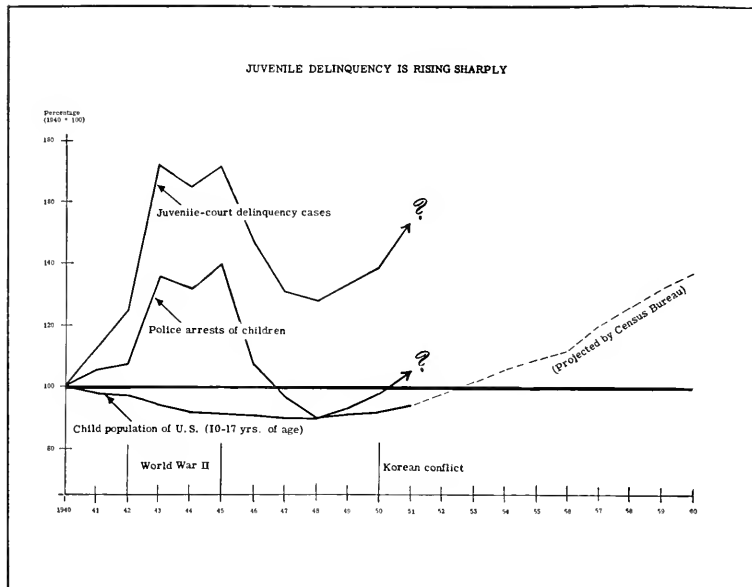
Of the remaining children, approximately 95,000 *were placed on probation* and the rest were either referred to other agencies, committed to institutions, or handled in other ways.

About 35,000 children a year are committed by juvenile courts to training institutions designed primarily for delinquents.

WHAT SERVICES ARE AVAILABLE?

At the present time we have no adequate information as to the number of police officers with special training for work with juveniles. (This information is currently being collected by the Children's Bureau and the International Association of Chiefs of Police.) The number needed has been estimated at 10,000, or at least 5 percent of our total number of police officers. A city with a population of 20,000 should have *at least one policeman* trained for work with delinquents.

A recent study of 177 cities, each with a population of more than 20,000, revealed that more than *one-third* of them have not yet made



special provision in their police departments for work with children.

The Delinquency Control Institute of the University of Southern California, which offers the only university-operated training program for juvenile officers in the country, has *graduated 173* persons since it was founded in 1946. A few other schools—the Police Training Institute of the University of Louisville, the FBI Academy, and local academies and police schools—do give some attention to police work with juveniles, but, so far as we know, this instruction represents only a small portion of the total curriculum.

There are more than *2,500 juvenile courts* distributed over the Nation. If the children brought before them are to receive even minimum help, a court needs sufficient probation service for study of each child's background and for guiding those children that the court places on probation.

The court should also have available to it a detention facility suitable for keeping children in secure custody. One detention facility may occasionally serve more than one court.

The number of such detention homes in the United States *is only 174.*

At least one-half the counties in the United States are without probation services for juvenile delinquents.

There are at present 3,716 local probation officers for juveniles. Many of these officers serve both children and adults.

In 1951 these officers had the major responsibility of serving not only 350,000 delinquent children, but also 150,000 dependent, neglected, and other children who are the concern of juvenile courts. In other words, there is *1 probation officer for every 135 children* coming to the court. Of course, this is only an average. Some courts have highly developed probation services, but many have none whatever.

About 30,000 delinquent children are in the more than 250 training institutions designed primarily for such children.

The average length of stay of a delinquent child in a training institution is somewhat *less than one year.*

RECOMMENDED FOR EVERY COMMUNITY

ON THIS PAGE are set forth certain desirable practices, or standards of practice, that have been recommended to communities seeking to improve their services for delinquent children.

The services considered here are those offered by the police, the juvenile court, the detention facility, and the training school—four agencies entrusted with a legal and social responsibility for helping our delinquent children become better-adjusted individuals and better citizens. In addition, standards for the organization and administration of these services are included.

The statements given here, which are part of a more complete list now being compiled by the Children's Bureau, were drawn from the publications and proceedings of a large number of national groups and organizations that are interested in preventing juvenile delinquency and in giving proper treatment to those children who have become delinquent.

These organizations, and others like them, are continuing to add to those standards and to bring them up to date. During the coming year, the Children's Bureau will lend encouragement to these efforts, and hopes eventually to have standards formulated for every aspect of our community's services for delinquents.

In the meantime, the list of existing standards should be useful not only in guiding the development of services in the areas covered but also to mark the areas not covered.

The selection of standards on this page covers just a few aspects of each service. The goals set forth are not new. They are familiar to many people. But there is not a town in the Nation that would not benefit its children immeasurably by making these simple statements come true.

State organization and administration

In every State government a single department should have authority and responsibility for coordinating services for delinquent children, developing standards for such services, establishing new services, relating these services to those of other agencies in the State, using the services of other agencies in the State, and stimulating leadership in local communities.

This State agency should have responsibility for aiding political subdivisions of the State in providing probation service and detention care.

This State agency should make consultation service available to the various agencies providing care and treatment to delinquent children, and should have responsibility for promoting the development and use of social services in juvenile-court cases.

This State agency should have a

clear responsibility for giving leadership and assistance in developing in-service training programs in all State and local agencies that operate programs for delinquent children.

Programs of service to children, including delinquent children, should be coordinated at the State and local levels by some form of planning and coordinating body.

Police

Instruction and training in the handling of juveniles should be a part of the basic training of every police officer.

Police officers with a major responsibility for work with children should have special training that will enable them to make constructive use of the broad discretion they have in handling each instance of juvenile delinquency that comes to their attention.

Law-enforcement agencies should participate along with other community agencies as full partners in the process of coordinating and planning services for children.

Police departments in urban centers should have a special unit devoted to protective and preventive work with juveniles.

Officers assigned specific responsibility with respect to juveniles should be assigned on a basis of personal fitness and capacity to work with children and youth.

Juvenile court

The juvenile-court judge should have legal training and should be a member of the bar. He should have sufficient knowledge of the sciences of human behavior to be able to use and to be willing to use expert advice on the problems of human relations.

Provision must be made for social study of the child prior to final court action and for the services of trained and skilled counselors to aid children placed on probation.

A probation officer should have, as a minimum requirement for appoint-

ment to his position, a bachelor's degree from a college or university of recognized standing, with specialization in the social sciences.

Probation officers should be appointed only on merit, without regard to political affiliation.

Child-guidance clinics, mental-health clinics, and psychological, pediatric, and other needed services for children should be made available to the juvenile court.

Detention

A delinquent child who must be kept in secure custody should be held in a detention facility designed and conducted for such children, and not in a jail or police lockup.

It should be possible to admit a child to detention at any hour of the day or night. All detention should be authorized by the court.

Detention must in every case be as brief as possible.

Every detention facility should have a plant, program, and staff that will enable it to make detention the first step in a constructive treatment process.

Training school

The training school should be sent only those children who are in need of and who can profit by its services.

In the training-school treatment process, an attempt should be made soon after a child's arrival to gauge his emotional and social maladjustments and their underlying reasons. A program of individual and group therapy should then be prescribed to correct them.

The director and staff should be selected on the basis of merit alone.

Psychiatric and psychological services should be available.

Children in training schools should have educational opportunities that are at least equivalent to those offered in the community.

An aftercare program should be maintained for the guidance of children released from the school.

COMMUNITIES ACT AGAINST DELINQUENCY

DOUGLAS H. MACNEIL

COMMUNITIES find out about their delinquency problem in a number of ways, and they go about taking action toward solving the problem in just as many different fashions.

Hundreds of cities and counties already have much information available about their delinquency problem. In these communities, local committees on children and youth collected facts for use in the 1950 Midcentury White House Conference. A number of these committees are continuing their efforts to bring these recommendations to fruition. In some cities, an official body—the welfare council for instance—may keep close tab on the situation and alert the community to any pressing need.

Elsewhere, the discovery that there is a delinquency problem may come as a surprise, and generally that surprise is apt to be unpleasant. I know of a number of cases like this and will mention a few of them here.

On Hallowe'en of 1950 such extreme acts of vandalism took place in Oneida County, Wis., that the need to do something about juvenile delinquency was plain. The local chapter of the Veterans of Foreign Wars soon went to work and helped organize a citizens' committee to find out why so many young people were getting into trouble. The State of Wisconsin helped Oneida County make a survey to see what was needed, and the community has gone far toward filling those needs.

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In Austin, Tex., a grand jury called the attention of the people to the problem of delinquency in that community. During February 1948, in the course of investigating the administration of justice in the county, the grand jury handed down a strict indictment of the way delinquent children were being dealt with. The jury proposed far-reaching reforms. The community council was asked to take on the job of getting interested individuals and groups organized in an effort to bring these reforms into being. Today the city of Austin, and Travis County, together have a new detention home, and the probation services of the juvenile court have been strengthened by the addition of new probation officers to work with delinquent children.

In Seattle, Wash., the brutal murder of a 16-year-old boy by other

juvenile inmates in the county jail finally made the citizens of that community aware of how greatly they had failed in their responsibility. For 5 years the juvenile-court judge and other officials had been warning the public about the terrible conditions under which juvenile delinquents were being held. But no group had responded to the judge's pleas, and he could not remedy the situation alone. It took a cruel and inhuman murder to awaken the public to the urgency of the need for better juvenile-court facilities. Today Seattle has a magnificent new Youth Service Center dedicated to the task of rehabilitating its delinquent youth.

Another case that comes to mind has to do with the establishment of the Child Guidance Clinic of the Oranges and Maplewood in New Jersey. For several years, the Mental Hygiene Committee of the Social Planning Council had urged the creation of such a clinic but without much response from the public. Then three boys from families with standing in the community stole weapons from a

These children in a crowded neighborhood find their recreation in the street. Recreation workers trying to prevent delinquency need to seek out children wherever they congregate.



collection of guns owned by the father of one and shot a passer-by in the course of what amounted to an act of armed robbery.

A newspaper editorial asked how such an episode could have been anticipated. The Council pointed out that, properly used, the proposed clinic might have helped. Thereupon the newspaper announced a substantial gift from its own corporate funds and then spearheaded an intensive drive for the clinic. This assured its establishment. Now several years old, the clinic is one of the basic community services for atypical children.

One man can do a great deal

In each of these communities, the need to do something about the delinquency problem had to be forced upon the attention of the public. And once the need was discovered, a group of people stimulated the community to action. But sometimes one key person, if he is determined enough, can open the eyes of a community to bad conditions affecting children. This person may be someone officially concerned—a juvenile-court judge, for example, or the chief of police. Or he may be just an ordinary citizen.

A newspaperman started the ball rolling in Monroe, Mich., back in the thirties. He first began to think about juvenile delinquency when he noticed how many of the news stories that crossed his desk involved children and young people. Soon he began to wonder what it was in the community life that was causing these kids to become delinquent, and what the officials in the town were doing to help these children and to prevent further delinquency. So, in his own words: "I wrote to half a dozen people in town I knew would be concerned, enclosed the clippings, and suggested we meet Monday."

Thus commenced a campaign that was to lead eventually to many improvements in Monroe's services for children, delinquent and nondelinquent. The juvenile court has been bettered; two policewomen have been hired to work with juveniles; recreational facilities have been expanded and improved. But these gains were

not easily won. They took 10 years of hard and sometimes frustrating work.

In Middletown, N. Y., a boxing promoter, disturbed by the social attitudes of some of the boys who came to watch his fighters train, set in motion a community program to meet the recreational needs of children who do not fit into conventional group-work or recreation programs. After much determined effort, he succeeded in obtaining support for his idea from virtually all civic and youth-service organizations in his community.

Fixing community responsibility

Of the many suggestions that could be drawn from these case histories of community action, I believe we should emphasize two in particular:

First, no matter who starts the campaign, a large and representative group of citizens must be brought in to participate. It isn't a job for one man to carry through alone. One man can do much to stimulate interest and to prod those who lag. But if a campaign is to be successful, it must have the backing of a lot of people. Which brings us to the second idea: People must be informed about every aspect of the campaign—*why* it is necessary, *what* it hopes to reach, and *how* the goals can be accomplished. The public is not apt to get very excited about raising salaries for probation officers, or sending a local policeman away for training to fit him for work with juveniles, or building a detention home, unless it knows why these things are necessary and what good they are expected to accomplish.

Individuals and groups undertaking such campaigns have found how essential it is to keep these two ideas in mind. In some cases they've learned by bitter experience how unpredictable the public can be—and also public officials.

Take the case of Lehigh County and its detention home, for example. Lehigh County is in Pennsylvania. Some professional people who work with delinquent children there undertook to bring to the community's at-

tention the need for a detention home. The story of the struggle that ensued before the home was finally secured is told in the September 1951 issue of the Quarterly of the Pennsylvania Association on Probation and Parole.

The campaign started back in 1932. School authorities conducted a survey of detention and made a report. No other groups were called in, however—and nothing happened. In 1937, in 1939, and again in 1943 the problem of detention came up—but nothing was done.

Finally, in 1946, the council of social agencies was asked by the probation office and the Family Service Agency to undertake a study of the problem. Professional workers for children were already convinced that a detention home was needed. But this time the public was going to find out that a detention home was needed. Citizen participation was sought.

A subcommittee heavily weighted with interested citizens was formed to study facilities for the care of delinquent children. The first thing they discovered was that Lehigh County *was keeping juvenile delinquents in jail*. This was *against the State law*. The law clearly and specifically stated that no city or county could detain adolescents in any jail where adults were confined. Clearly the law was being violated. No one seemed very concerned.

But the subcommittee was disturbed. It went to work figuring out plans for a detention facility. And fortunately at this point it called in the chief probation officer of the local juvenile court to give guidance and advice. Later on, the National Probation and Parole Association was asked to advise on specific details of the construction of the home. Technical advice of this sort is nearly always necessary.

After about a year's work, the subcommittee came out with an excellent report on the need for detention facilities, and the executive committee of the council approved it overwhelmingly.

A lot of publicity was given the report, but a way had still to be found

to keep the issue alive and to press for action. A citizens' committee was formed. Composed of some 20 individuals representing industry, labor, clubs, professions, and other interests in the community, the committee was led by a man described as having the tenacity of a bulldog. He opened the meeting with words to this effect: "If any one of you thinks I am going to be chairman of a committee that is going to do nothing, and forget this report, each and every one of you has another guess coming."

The citizens' committee went about its task in the most direct way possible: political action. By now, it was election time—September 1948. All the candidates for county office promised to take up the matter of the detention home the moment they got into office. This was very satisfying. But, once in office, the elected commissioners allowed the budget to get through *without mention of a detention home*.

This was a blow, but the committee took it standing. They had been strengthened in their determination by a little demonstration staged by the chief probation officer that, although not generally to be recommended, left a lasting impression. Three or four youngsters under 13 who had been picked up and placed

in the county jail for some delinquent act were brought to a meeting of the committee. No one knew their names or what they had done. The committee saw simply a small group of ordinary youngsters. These children were not criminals, to be kept in a jail.

The campaign for a detention home went on. A mass meeting was held. The grand jury recommended that the home should be built. And finally a lawyer on the committee "... began to talk of the possibility of mandamus proceedings against the county commissioners ... to compel these public officials to do their duty."

With that the battle was won. The county commissioners shortly thereafter voted funds and authorized the drawing up of plans for a detention home. Today Lehigh County has a detention home that it feels is "second to none in the Commonwealth."

Steps in a community action program

Perhaps these case histories have served to point to the steps a community may have to take in an action program. Of course the situation will vary considerably from community to community, but in general there are several definite stages in any campaign.

1. *Someone has to start the campaign*—either an individual or a group.

2. *Other interested individuals and groups must immediately be invited to participate.* Many communities have a Community Chest or Council that can serve to coordinate the efforts of individuals and groups. In some others the committees organized on behalf of the 1950 White House Conference may serve as the coordinating body. Still another unifying agent may be a coordinating council or youth-guidance council organized for the specific purpose of improving preventive and treatment services relating to delinquency.

Often it will be found that the problem about which a group is concerned is one that has also worried other groups in the community. If these groups join forces, the probabilities of a successful solution are enhanced. Or it may be found that someone else has thought of a different solution from the one a particular group has in mind. My advice in this case is, explore all the alternatives and try to reach an agreement as to what should be attempted. Nothing is more fatal to community progress than conflict over which solution or which organization should take precedence.

3. *The need must be well defined.* Sometimes the need is self-evident. If a juvenile court has no probation

Does your community give every child a fair chance starting out in life? Children in slum neighborhoods face some obvious handicaps.

These children live in a reconstructed neighborhood. Healthful surroundings encourage self-respect and respect for one's community.



service, it is obvious that such a service should be provided.

In other cases, however, the situation may be more complex. For example, an interested group may believe that the community needs a detention home. Study reveals, however, that most of the children who come to the juvenile court would be better served in their own homes or in foster homes, with improved probation service. A detention home in this community would therefore be a needless expense.

In those cases where the need is not clear and precise, a survey is generally to be recommended. Existing services should be measured. Every effort should be made to find out what the need is and how it can best be filled.

In case a full-scale survey is called for, to determine what the community is doing—or *not* doing—for all children, special consideration can be given the problem of delinquent children.

4. To get accurate data on its needs, a *community or neighborhood* quite often requires the assistance of consultants.

In Cleveland, Ohio, a citizens' group in a high-delinquency area used a survey made by skilled workers from the Welfare Federation of that city. The Federation also assisted in a follow-up campaign in the neighborhood, a campaign that led, over a 10-year period, to a 70-percent reduction in delinquency in the area.

In the case of Oneida County, Wis., mentioned previously, the citizens' committee was helped by the Division for Children and Youth of the State Department of Public Welfare. A State worker went to the community and, with the help of local citizens, conducted a thorough survey of the services and resources available to young people.

In addition to Wisconsin, a number of other States offer consultation service, related to juvenile delinquency, to local communities. California, Minnesota, Rhode Island, Illinois, New York, Kansas, Texas, and Mississippi all offer assistance through the Department of Welfare

or a Youth Commission, or other public body.

In my own State of New Jersey, this service is given by the Department of Institutions and Agencies through its Division of Community Services, of which I am the Director.

Sometimes it is wise to consult the State agency in this field even though you may see no immediate need for help. In a number of instances, our Division has been able to bring two groups in the same community together, both of which perceived a need, but both unaware of the potential ally next door. A parallel service has been to bring groups from adjoining communities together so as to develop joint programs which neither community could operate successfully alone.

In New York State, in addition to the advisory service it offers, the Youth Commission has funds that can be granted for community youth service projects under certain conditions. No other State has a similar grant-in-aid program. But it has sometimes been possible for us in New Jersey to help local projects qualify for help through existing State or Federal grant-in-aid programs. A community group should not build hopes on such support, however.

In addition to these State agencies that offer consultation service, a number of voluntary organizations will go into a community, when invited, and help local citizens survey their needs and resources. In the delinquency field the National Probation and Parole Association is an outstanding organization of this type.

Perhaps it would be helpful for me to try to be a little more specific about the ways in which a group of citizens can obtain counsel and other assistance for their program of bettering the community's service for delinquent children.

I suggest that the committee members first explore the resources right there in agencies, if there is one. This group usually bears the name welfare council, welfare federation, community council, community chest, or the like. Its purpose in most cases

is to act as a pool for all available social knowledge and resources in the community.

Failing a local resource, the group of citizens can go for assistance to the State planning body for children and youth—the group that cooperated with the Midcentury White House Conference. Nearly every State has such an organization, usually appointed by the Governor. The Governor's office can give an interested group the address of this organization. Generally, these planning bodies will be able to put a community group in direct contact with the State agency or voluntary organization that can best serve them.

Any local group or individual that cannot get help or doesn't know where to apply for help in their own State can get that information from the Children's Bureau of the Federal Security Agency in Washington, D. C.

5. *Publicity is the next step in the campaign.* Once the community's need has been well defined—either by general agreement or by survey—the report should be made known to every citizen in the community. Newspapers, mass meetings, radio interviews—these are all accessible to any group.

6. The final stage in the campaign is to *press for action*—wherever and however necessary.

In some instances, a single official may be persuaded to bring about a much needed improvement. A police chief, for example, may agree to assign one or two of his men to work with juveniles, and to inspect public places that may be tending to contribute to delinquency.

Or a group in the community can assume new responsibilities. A private social agency, for example, may accept for treatment cases referred by the juvenile court.

But, quite often, the force of the entire community may be necessary to achieve what seems to be a very simple objective. For example, it took Lehigh County almost twenty years—and talk of mandamus proceedings—to secure a detention home. This was no quick and easy solution.

Indeed, there is seldom any quick

and easy solution or any permanent one. A youth-service facility can deteriorate—quickly or slowly. To assure long and fruitful life, continuing citizen interest is essential.

Perhaps the group that initiated or sponsored the project can transmit its responsibility to some successor organization. But, in the long run, the responsibility for seeing that community services sustain a high level of quality is likely to rest upon the same organizations, the same civic groups, the same individuals that fought for their establishment in the first instance.

In other words, we must be realistic about our community action programs in the field of delinquency. Delinquency springs from social conditions that are deeply imbedded in community life. They cannot be eradicated overnight. But, with constant and patient effort, the public and its officials can be given a better understanding of the dangers of delinquency—and be persuaded to take measures to help children avoid serious maladjustment in their personal and social life.

The newspaperman who started the community effort in Monroe, Mich., has summed up his group's efforts in this clear and forthright way:

"Kids still run wild at times . . . Cops still lecture miscreants and let them go. The new, alert judge still has no place to send kids not quite bad enough for reform school but too tough for foster homes.

"On the other hand, in large part, both the community and officialdom now admit that delinquency *does* exist, and both are doing something, if not all they could, about it. And, gradually, trained personnel is being employed by the agencies dealing with children and youth. Because the community is awake, it is easier now to get official action, whether for a new detention home or increased funds for foster-home care. But the battle must go on . . . Eternal vigilance is the price of civic virtue."

Are not these words both honest and hopeful?

REPRINTS ON JUVENILE DELINQUENCY

A number of recent articles on juvenile delinquency, reprinted from *The Child* and other publications, are available for distribution. Single copies may be had without charge until the supply is exhausted.

Boys and Books Get Together. By Leita P. Craig. Reprint from *The Child*.

Citizens Help a Juvenile Court. By Charles H. Boswell. Reprint from *The Child*.

The Institution as Therapist. By George E. Gardner, Ph.D., M.D. Reprint from *The Child*.

Learning Casework in a Juvenile Probation Setting. By Elliot Studt. Reprinted by permission from *Social Casework*.

A Look at Our Training Schools. By Richard Clendenen. Reprint from *The Child*.

New Horizons for Youth. By Bertram M. Beck. Reprinted by permission from *Ohio Probation*.

Probation Work Requires Special Training. By Clarence M. Leeds. Reprinted by permission from *Federal Probation*.

To Synchronize the Training-school Program With Life in the Community. By Richard Clendenen. Reprint from *The Child*.

Training Schools and the Future. By Richard Clendenen. Reprint from *The Child*.

We Can Do Something About Juvenile Delinquency. By Martha M. Eliot, M.D. Reprint from *The Child*.

Why Does a Young Delinquent Resist Treatment? By Harris B. Peck, M.D. Reprint from *The Child*.



Dec. 1-2. National Midcentury Committee for Children and Youth. 2-year anniversary conference. With the Advisory Council on State and Local Action; the Advisory Council on Participation of National Organizations and the Federal Interdepartmental Committee on Children and Youth. New York, N. Y.

Dec. 2-4. National Conference on Labor Legislation. 19th annual meeting. Washington, D. C.

Dec. 5-12. International Study Conference, held by the International Union for Child Welfare. Bombay, India. Information from the International Conference of Social Work, 22 West Gay Street, Columbus 15, Ohio.

Dec. 7-8. The Associated Women of the American Farm Bureau Federation. 18th annual convention. Seattle, Wash.

Dec. 8-11. Association of State and Territorial Health Officers. 51st annual meeting. The Association will meet with the Surgeon General of the Public Health Service and the Chief of the Children's Bureau as well as the State Mental Health Authorities and the State Hospital Survey and Construction Authorities. Washington, D. C.

Dec. 9-11. American Farm Bureau Federation. 34th annual meeting. Seattle, Wash.

Dec. 10. Human Rights Day. 4th anniversary of the Universal Declaration of Human Rights.

Dec. 14-19. International Conference of Social Work. 6th worldwide meeting. Madras, India.

Dec. 27-29. American Economic Association. 65th annual meeting. Chicago, Ill.

Dec. 27-30. American Statistical Association. 112th annual meeting. Chicago, Ill.

Dec. 28-30. American Anthropological Association. Annual meeting. Philadelphia, Pa.

Dec. 29-31. American Association for the Advancement of Science. 119th annual meeting. St. Louis, Mo.

Area conference. National Child Welfare Division, American Legion:

Dec. 4-6. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.

To Our Readers—

We welcome comments and suggestions about **The Child**.

FOCUS

(Continued from page 62)

We need more personnel, and better-trained personnel. This need continues from year to year, despite the fact that if we could somehow offer full and effective services to delinquent children and their families, we could probably prevent development of a major portion of adult criminality.

Aiding one delinquent child to become a good citizen may prevent the spread of delinquency among many other children. Behavior of adolescents is greatly influenced by that of their friends and companions. Improved court services available to delinquent children could reach into the most distressed families in our communities. Study upon study has demonstrated that delinquency most often occurs in a family subject to a variety of social ills. These are families, that though few in number, use up the lion's share of the social services established in any particular community. These are also the families most often shunted from agency

to agency because the depth and severity of their distress makes it difficult for them to be assisted.

It is because of the great gains that may be made by improving services to delinquent children that the Children's Bureau has established its Juvenile Delinquency Branch, which is assisted by a Special Juvenile Delinquency Project, sponsored by the Children's Bureau and financed by private contributions made to the Child Welfare League of America.

The Branch and Project together are trying to stimulate State and local action to improve public services for delinquent children. Improvement of such services is not sought as a substitute for more inclusive measures to prevent maladjustment or to serve children who are not in conflict with the law but who need help.

The antidelinquency program is a small segment of the Children's Bureau's total effort to aid parents in rearing children and to aid children from families that have been unable to give them sufficient care.

Services to delinquent children must be seen as a part in the over-all picture of child-welfare services, but in seeing the whole, we cannot neglect the special needs of groups of children within that whole.

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THE CHILD

JANUARY 1953



SHOULD CHILDREN BE SEPARATED FROM THEIR PARENTS?

DRAZA B. KLINE

CHILDREN who are sent to an agency for placement are always in some degree emotionally damaged. The unfortunate family experiences that lead to separating a child from his parents and the injurious effect of that separation interfere with a child's normal personality development and cause various psychic disabilities. Therefore every placement should be planned as treatment to improve the child's emotional health.

The responsibility of the social agency, the child-guidance clinic, the psychiatrist, the psychologist, and others using placement to improve a child's emotional health is greater than is generally recognized. Part of this responsibility is to know, as in medical practice, the exact nature of the treatment and the secondary damage it may cause, so that it can be weighed against less radical measures. This means that any worker who refers a child for foster-family care needs to be acquainted not only with the potential values of placement but also with its potential hazards—the shock to the child when separated from his parents, the harmful effect on the parents, the pain of foster-child status, and the dangers in changing homes.

Placement means different things to different children, but for many a child we find that being separated from his parents means that he was either so bad or so unlovable that his parents *had* to give him up, or even wanted to. The stigma of being a foster child, different from other children because of his parents' failure, is clear to himself and to some members of the community, who may bring this to his attention in many hurtful ways. The longing to be reunited with his own family, to be accepted by his parents, and to live,

like other children, in his own home, persists in some degree throughout his separation.

To his parents, the separation also has its evils. A parent who is unable to care for his own child is, in his own eyes, a failure. When he cannot meet this most basic requirement of our culture, the damage to his ego is inestimable. For some this can later be overcome; for others it leads to further damage and decreased capacity for interest in and responsibility for the child, despite the best efforts of the caseworker.

Child may lose home after home

Perhaps most serious of all is the fact that child-welfare agencies cannot offer a child long-time foster care with assurance that he will not be taken out of that home and placed in another, thus suffering again from separation and loss. Foster parents, like other people, meet disrupting changes in their lives. They move to other parts of the country, they have serious illnesses, deaths, financial crises, emotional crises. A child is born to them, or a relative who needs their care moves in. Any such change may make it necessary for the family to give up the child. These factors, however, account for only a minor number of changes for individual children; a greater number occur because the child is so severely disturbed that there seems no way to treat him. The child is removed from home after home because the trouble

for which he needed treatment at first makes his care intolerable to foster parents, or because his own parents are unable to cooperate with the foster parents.

The potential dangers of placement must be weighed against the injurious influence of the child's own home. Before we decide that a child should be placed in a foster home it should be clearly established that the family situation is predominantly injurious to the child. For if this situation can be improved sufficiently it is better to keep the family together.

Sometimes there is no alternative to placement, but frequently the decision must be based on factors that are not clear cut. In these cases a wise decision must be based on a comprehensive diagnostic study. Such a study should include an accurate assessment of the character and personality development of the child and his parents, of the family interrelationships, of the causes of the family's current failure. We need to evaluate the interaction of the psychological, social, and economic factors in the family situation. From such a study we may determine with reasonable assurance how bad the situation is and what can be done.

When it is decided that the family situation is predominantly injurious to the child and that the child cannot be treated in his own home, two additional questions must be considered:

(1) Is there a family available that can care for the child in such a way as to improve his situation? (2) Can the child and his parents be helped by placing him? If the answer is No to either question, the agency's efforts to give service are wasted. For example, a seriously disturbed child too often is obliged to enter on an endless succession of moves from one home to another.

DRAZA B. KLINE has been Director of the Foster Care Division of the Illinois Children's Home and Aid Society for the past 6 years. Before that she was for several years on the staff of the Bobs Roberts Child Guidance Clinic at the University of Chicago Medical School, and she supervised a student-training unit for the School of Social Service Administration. Miss Kline's training was at the University of Minnesota and the University of Chicago.

This paper is condensed from one given by Miss Kline at the seventy-ninth annual meeting of the National Conference of Social Work, held at Chicago, July 1952.

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Likewise, when a parent is incapable of having a satisfactory parental relationship with the child and yet cannot permit him to have it with substitute parents, we are likely to provide a psychologically untenable situation. The parent's behavior makes it impossible for the child to feel that he belongs with either set of parents and makes him hostile toward both. Thus with neither love nor consistency, the minimum conditions necessary to healthy personality development are absent, and the child is increasingly disturbed.

To treat the "untreatable"

For us to busy ourselves with such unproductive and costly services violates our responsibility to the child and to the community and damages resources that could be used advantageously for other children. Our responsibility to the so-called "untreatable" child is to develop, in some way, an effective method for treating him.

In cases in which the factors are not clear cut, joint examination by the referring agency and the placement agency would help both of them to understand the case and hence to select the appropriate service.

Just as the decision whether a child should be placed in a foster home is based on a comprehensive analysis of the child and his family, so is the selection of the new home. The more fully we know the characteristics of the available foster homes or institutions, the better we are able to select the one that will most nearly meet

the child's needs. In the following case story about the J family, I will describe some of the methods of planning for placement which the staff of the Illinois Children's Home and Aid Society, under the psychiatric direction of Dr. Margaret Gerard, have found useful.

The case illustrates: (1) a basically injurious and unmodifiable family situation; (2) diagnosis and evaluation of the three children beginning at the point of intake and continuing throughout the service; and (3) differential placement planning, based on their individual personality development, the characters of the parents, the family interrelationships, and the characteristics of the available resources for treatment.

Mrs. J was referred by a child-guidance clinic for placement of Bill, her 5-year-old son. (Later, two older sisters, Ann, age 7, and Norma, age 9, were also placed in foster care.) The first study revealed that the parents, then in their late twenties, had been in severe conflict throughout the 10 years of their marriage. They had been known to various community agencies from which the mother sought help each time the marriage reached a crisis.

The trouble had begun shortly after the birth of the first child, with the crises building up from the mother's nagging and the father's periods of alcoholism and brutal attacks on the mother. These episodes were followed by separations and reconciliations. The mother sought help from agen-

cies only in financial desperation or in an attempt to punish her husband, but she did not wish to give up the marriage. She wished only to give up the children.

The increasing tension between the wife and husband, which resulted in placement of the children in a foster home, seemed to arise in part from the mother's increasing fear of pregnancy and the inability of both parents to tolerate the responsibility of caring for three children who were becoming more and more difficult to handle.

This application for foster care for Bill came at a time when the parents were separated and the mother could no longer endure caring for Bill. She said she "yelled at him and beat him," and wanted to "put him out of the way," but she could not comply with the father's wish to give him up for adoption because she felt she had to be able to see him to be sure that he was well taken care of. She attributed this to her own experience of living in an institution for 5 years in her childhood and knowing how it felt to be neglected. (Later, however, she told of being removed from the institution at the age of 10 to live with her father and new step-mother and wanting to return because she had liked the routine, the recreation, and the other children.)

When the mother was pregnant with Bill, the father had urged her to abort, which she refused to do. After Bill's birth, the father ignored him except when drunk; then he was abusive to him. At home Bill was fretful and demanding, except that sometimes, when alone with the mother, he sat quietly and asked her to read to him. When the father was at home Bill frantically urged the mother not to go into the bedroom with father but to stay with him. He was often heard to say, "Why doesn't Daddy die?"

This history shows all the conditions that point to a need for foster-home care. The conflict between the parents had been violent and persistent over a period of many years. Both parents openly rejected the child. Both parents repeatedly refused help in solving their marital

Each child in a family has his own individuality—his own personality and his special needs.



problems, which were destroying the family.

First try unsuccessful

Foster care for Bill was considered in relation to his age, his symptoms, and his relationships with his parents. His warm reaction to the caseworker indicated that his severe symptoms might have been the result of the beatings and the rejection he was suffering at home, rather than arising entirely from internal conflict. If so, he could improve in a good foster home. Bill needed foster parents that not only offered stable family life and gave him consistent affection and care, but also had the ability to treat his impulsiveness firmly. He needed a foster father who could permit Bill to test him in his role as father and thus to change his concept of a father as a cruel person.

After first making an unsuccessful selection of foster parents we realized that for Bill foster parents would also have to have an unusual degree of personal security because he drew close to the foster father and excluded the foster mother. He needed more than "good parenting"; he needed treatment within the framework of consistent parental affection and care.

We accordingly placed Bill in another foster home, where he has remained for the past 4 years. Bill's progress in this home has been steady but slow. The intensity of his symptoms gradually decreased, but the core of his neurosis has not yielded even to excellent environmental treatment. His need for direct psychotherapy is recognized by the foster family and the agency, and plans are pending to make this available to him.

Two months after Bill's placement, the parents were ready to request foster-family care for Norma and Ann. The mother had wanted this earlier, but the father, because of his attachment to Norma, was opposed to it. However, after an episode in which he attempted to choke the mother, he recognized that the children were terrified by the constant fighting, and he, too, requested the agency to place the girls.

The placement of the two girls will illustrate the way in which the plan for foster care is related to the parent-child relationship, the sibling relationship, and the child's personal needs.

We learned from the parents that Norma, the oldest child, was the favorite of both. The mother was dependent on her, confided in her, and had relied on her to mother the two younger children, because Norma could be more firm with them than she. The father looked to her for companionship, taught her music, and treated her, in general, as an adult.

Norma, in turn, was attached to both parents and resisted placement. She had enjoyed the position of favored child, but this was a precarious position since both parents were too immature to have a consistent relationship even with the favorite, and she was often in the role of trying to protect one parent from the rage of the other or competing with one for the attention of the other. In addition, her responsibility to the other children at too early an age made her hostile to them and to her parents. She was bossy, defiant, selfish, and aggressive. She had recently begun to steal, taking rather large sums of money from adults and toys from other children.

The younger sister, Ann, was consistently rejected by both parents, but the mother was not unkind to her. The father had never liked her and he would slap her or send her to bed upon the slightest provocation. She was conforming, timid, and extremely fearful of men. She did well in school, but she was nervous and had vomiting spells with no apparent physical basis. Her relationships with other children were satisfactory. She and Norma were described as inseparable companions.

It is clear that in psychological development, needs, and relationships to each other and to the parents the two girls were strikingly different. All these factors had to be considered in planning for foster care. Because of Norma's complex attachment to both parents, her resistance to placement, and the parents' attachment to her, it could be foreseen that she

would be unable to accept a relationship with substitute parents and that her parents would be unable to free her to do so. Also it was apparent that she needed intensive casework help to resolve her conflict about the separation, correct her distorted concept of her triangular role in the relationship between the parents, and realistically evaluate her relationship to each of them and their meaning to her.

For Ann, from the standpoint of her age and the lack of complicated involvement with the parents, one would first consider foster-home care, but two factors suggested a different plan. First, her fear of men needed to be observed in a setting where its intensity could be evaluated, without subjecting her to too great anxiety from close proximity to a foster father. And secondly, the meaning of the relationship between her and Norma was not sufficiently clear to show whether the development of both girls would be facilitated by separating them or by placing them together.

Sisters placed in group home

Ordinarily, we would wish to place these children together. But with emotionally sick families, where the children have had to share the meager love of immature parents, the ordinary relationship between brothers and sisters usually is supplanted by rivalry and hostility. Failure to recognize this before placing children of the same family together often leads to the necessity to separate them later and place one of them with another foster family. When this occurs the child who remains in the home may feel responsible for his real or imagined part in pushing out the child that he hated; the one who leaves may feel that he is so "bad" that not only his own parents can't love him, but neither can the substitute parents, who *can* love his brother or sister. Such conflict can be modified through skillful casework help, but it is safer to avoid those damaging complications whenever possible, even if this means a temporary period in an institution. For these reasons it was decided to place both girls in

the agency's group home.

In the early months it was noticed that during the parents' weekly visits they centered their attention on Norma and were indifferent to Ann. This confirmed the depth and extent of the neurotic involvement in the relationships between Norma and the parents, and it could be foreseen that this would not be quickly dissolved, if ever.

In the group home Norma was extremely jealous of Ann in her relationships with other children and with houseparents. She felt displaced by Ann when she could not establish herself as the favorite. She tended to domineer and boss Ann in all activities. Ann gradually withdrew from Norma's domination and responded warmly to kind, protective care. We soon realized that the two girls needed to be separated. Norma's relationship with the parents had to be continued on a regular basis and under adequate supervision, since neither she nor the parents would be able to tolerate separation. Ann, on the other hand, showed no need for the parents when substitute relationships were offered her.

After a year in the institution, Ann's fear of men seemed to have disappeared, as a result of her experience with kind and consistent male staff members and the help the caseworker gave her in expressing her fears and clarifying the difference between men.

As she drew away from Norma, she developed her own friends and interests, and became an attractive, vivacious, lovable youngster. We realized that she needed to be cherished by sensitive foster parents to give her the long-time, sustained protection from hurt that would decrease her vulnerability to rejection. She was placed with foster parents who had some wish to adopt her. They were outgoing, friendly, gentle, and sensitive. The foster mother delighted in caring for her—sewing and selecting clothes for her and providing healthful group activities. Ann enjoyed the experience of seeing herself as a loved and worthwhile person in the eyes of both foster mother and father. Like Bill, she has now been in her present

home for more than 4 years.

Norma, because of the problems already described, remained for 3 years in the agency's institution, where it was possible to provide regular casework treatment. When she showed more capacity to deal realistically with herself and her parents and greater personal security in her performance in school and in music, she was moved to a girls' school. This school was selected because the program offered minimum demand for personal relationships; a full program of activities; opportunities for recognition for performance in the various areas of her talents, such as music and art; and routines and rules that would help develop the conforming side of her nature. In such an environment, this child could develop skills without being thrown into further conflict by interference with her ties to her parents or by demand for closer relationships with other adults.

She has made as much progress as possible for a child so damaged by neurotic parental attachments. She has begun to take pride in her performance as such, as contrasted to earlier intense and anguished rivalry with other children.

The agency's work with the parents, throughout the 5 years these children have been under care, has been based on the initial evaluation of their characters and the meaning of the relationships between them and the children. The father eventually withdrew from all contacts with the agency and the children. Our efforts to help the mother, geared toward enabling the children to maintain and use their placements constructively, have included keeping her closely informed about the children, thus easing her feeling of guilt and her sense of worthlessness as a parent, helping her verbalize rather than act in regard to the children, and freeing her from financial responsibility for their care at points where she was unable to pay. We have used this method to help this basically dependent, distrusting mother to trust the agency with the care of her children, since it was only through experiencing such care her-

self that she could permit the children to experience it. Through this kind of relationship she has been able, for the most part, to respond to the guidance of the caseworker and act on the agency's advice for the best interests of the children. The present immediate casework goal is to help her relinquish Ann and Bill for adoption and to maintain Norma's placement until she has completed high school.

We see here how the study and treatment center served several important purposes. The girls' relationships to their parents and each other became clear. The desirable degree of separation from each other and from the parents could be evaluated and the degree of individual personality damage determined. The planning of institutional care for Norma and foster-home care in a potential adoptive home for Ann was based on evaluation of this combination of factors. In addition, the casework treatment, in this neutral but protective setting, prepared them for the types of care in which they could develop.

The use of a diagnostic and treatment center is not typical of the cases studied in a placement agency, but the areas of observation, diagnosis, and evaluation delineated here are applicable to all cases. Less complex cases can be studied while the child is in his own home.

Many factors to be weighed

A child separated from his family is a complicated human being, and the therapeutic resource consists of one or more human beings, less complicated but nevertheless subject to the usual human responses. The objective of the principles and methods discussed is to bring these two together, not in predefined, categorical combinations, but rather with reference to the infinite variations in each personality, to meet the distinctly different needs of each case. To do this, we must weigh all the known factors and arrive at a conclusion that satisfies the demands of our current knowledge of personality development and individual dynamics, of the meaning of family relations, and of the unique characteristics of placement.

Reprints in about 6 weeks

SICK CHILDREN BENEFIT FROM A CITY'S HOME-CARE PROGRAM

VIRGINIA INSLEY

IN RICHMOND, VA., the city health department's program for home medical care does more than just send a city doctor into the homes of people who are too sick to go to a clinic and who cannot afford to pay a private doctor. The program gives complete care to these patients, integrating its home medical service with the services of clinics, hospitals, and other agencies in the fields of health and welfare. The home-care program provides the services not only of physicians, but of medical social workers and public-health nurses.

The home-care program also works to improve medical education by introducing future practitioners to family social and economic problems that affect their patients—something their hospital training as a rule does not do. The opportunities given these young men and women to discuss with physicians, public-health nurses, and medical social workers the situations that they observe in patients' homes undoubtedly will make them better doctors.

More than half the patients who receive home care are under 20 years of age; large numbers are under 4. And besides the children actually treated, many more benefit through the home-care services provided to their families.

Until the present home-care service began to function, in 1949, the health department was giving a limited kind of home medical care to patients who could not get any other.

For many years, in each of five districts of Richmond, a part-time doctor, employed by the year, was assigned by the department to visit patients in their homes, with an additional doctor to provide for a rotating assignment to answer night calls. One of these physicians would visit a patient, often after some delay, but

unless he was specifically called again he did not return.

If the patient was taken to a hospital, the physician who had called at his home did not see him in the ward, nor later in the out-patient department. Nor was any record given to the physician of ward or out-patient treatment. After a patient had been discharged from the hospital the city doctor did not keep in touch with him. Often the patient did not follow the hospital recommendations, with the result that he had to be returned to the hospital for further care.

Social workers and public-health nurses found it impossible to get the kind of medical support they needed in caring for a patient at home.

The cost of the program was high and the medical results were poor.

The Director of the Health Department realized that the system was unsatisfactory both from the humanitarian and the economic standpoint. He felt that if sick people were diagnosed sooner, if they were cared for with some continuity, and if the social and emotional factors in their illnesses were considered by the doctor who visited them, the program could be worthwhile. Fewer of the patients would become severely ill, and more would be restored to a productive place in the community. Also, fewer people would need hospital care, and the cost to the city of caring for the sick would be reduced.

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Miss Insley has worked in the Washington State Health Department and in the Social Service Department of Beth Israel Hospital, Boston.

For 2½ years Miss Insley was on the staff of the Department of Public Health, Richmond, Va., where she initiated social services in the health department and carried special responsibility in connection with the home-care program that she describes here. She has recently joined the staff of the Children's Bureau.

In 1947, the Director of the Health Department asked the Richmond Area Community Council to appoint a committee to study the whole problem and recommend a better plan.

The committee worked for a year on the problem, consulting many persons concerned with health and welfare, such as practicing physicians, nurses, and social workers, and members of the faculty of the Medical College of Virginia.

In conference with the committee, members of the Medical College faculty discussed the fact that medical students, internes, and resident physicians in the two hospitals affiliated with the College had no opportunities to observe, and try to solve, patients' personal and family problems, the kind that doctors have to face in practice. The patients seen by these young men and women usually were brought to them because of some advanced, unusual, or obscure condition, and no patients were seen under the circumstances of usual medical practice, that is, at home.

Joint plan adopted

It seemed clear that the College would gain an important teaching advantage if it accepted responsibility for cooperating with the Health Department in providing well-supervised medical care to patients in the city's low-income group, and that the patients would benefit tremendously from this care. And apparently the cost to the city would not be higher than it had been, and might be lower. Therefore both the Health Department and the College favored a plan for joining forces in providing home care to the sick.

After careful consideration all around, and with the approval of the Richmond Academy of Medicine, the committee recommended that the city adopt the cooperative plan that is now in operation. A grant from the Commonwealth Fund made it possible

to start the program as a demonstration; it was continued until the Health Department and the Medical College were able to take over full responsibility, in 1952.

Under the plan, which is part of the over-all program of Richmond's City Department of Public Health, Medical College faculty members on the staff of the Health Department are responsible for supervising the medical care given by the department in the homes and for coordinating this care with any hospital care in a ward or the out-patient department. The medical staff of the program consists of three physicians who are faculty members, one of whom is clinical director of the program. These three physicians supervise the work of seven senior students, as well as of three resident physicians assigned to the two hospitals affiliated with the college. Each student serves on the home-care staff for 3 weeks; each resident for 10 weeks.

When a call comes in from a sick person's family, or from any individual or agency interested in the case, two senior medical students are sent to visit the patient. (The students are not accompanied by a physician on their first trip to a patient's home, as the program believes that this detracts from the students' interest and feeling of responsibility.)

After examining the patient, analyzing an impression of his personality, and studying his household, the students make a tentative diagnosis. They then go back to the clinic that is their office and write a brief report, which contains the salient facts about the patient's medical and social problems. The report should include notes on any physical conditions in the home that might affect the patient's health. A resident physician reviews the case with the students, and then all three go to the patient's home. After this visit they discuss the case with one of the three supervising physicians, who may also visit the patient's home if he considers this necessary. A pediatrician paid by the Health Department is available for consultation.

If the supervising physician decides that the patient needs to be



Home medical care can make a valuable contribution to a total health and welfare program.

treated in the hospital or in a special clinic, this is done, and the case is followed throughout the treatment and afterward. Home visits are continued, if necessary. If laboratory work is needed, or X-rays, these are provided; likewise facilities for physical medicine. Social service and nursing care are available, and sometimes homemaker service, all paid for by the Department of Health.

For patients who continue to be treated at home, such sickroom equipment as hospital beds and wheelchairs can be rented at the expense of the Health Department. Drugs and dressings are provided by the department, with some help from the Cancer Society.

Medical students and residents are expected to obtain the facts of the family's social situation as well as the medical problems; they are helped to understand the social factors by members of the social-work staff, who participate in daily discussions among students, residents, medical preceptors, and the clinical chief. Members of the medical staff and the social-work staff, medical students, social-work students, supervisors

from public-health-nursing agencies and the director or assistant director of the Health Department attend two clinical conferences each week, in which home-care cases are presented by medical students and discussed by the entire group. Social workers from the Welfare Department are invited when cases known to them are discussed.

Integration of services necessary

Since the idea of the present home-care program was first conceived, the Health Department recognized that the program could succeed in fulfilling the community's needs only insofar as it could be integrated into the structure of health and welfare services. Integration of medical services to patients seen at some points by home-care physicians and at other times, often within a few days or hours, by physicians in hospitals or clinics, is of course essential to quality, continuity, and economy of medical care.

Abbie Watson, Director of Richmond Instructive Visiting Nurse Association, discusses the cooperation of nursing agencies in an article entitled

"The Public Health Nurse in the Richmond Home Care Program" (*Public Health Nursing*, May 1952).

Social agencies in Richmond refer sick children to the home-care program for medical visits; they also give social services when these are requested, and they exchange medical and social data with the social-work staff of the program. The agency most concerned is the city's Welfare Department, which, through Aid to Dependent Children, contributes to the support of a large number of the children who receive medical care at the city's expense. This department is also responsible for the care of a number of children in foster homes who receive home medical visits. These children often have medical and social problems that require close cooperation between the home-care program and the Welfare Department.

Valuable service to children has been given by the Welfare Department's protective services in dealing with social conditions discovered through home-care visits. And the doctors on the staff of the home-care program have been helpful in evaluating the physical care given children by parents accused of neglecting them.

Program follows through

An example of the way the program works to give complete care to a sick child, from the onset of an acute illness through convalescence, is the case of 13-year-old Edna:

When Edna fell ill, with a very sore throat, her aunt, with whom she lived, telephoned to the city Health Department for a doctor. Two senior medical students went to the three-room apartment where Edna and her aunt lived. The apartment had running water, but it had only an outside toilet.

The students learned that since the death of the aunt's husband, she and Edna had been supported by payments from his insurance, but that these had come to an end, and that she had applied for public assistance.

After examining the child, the students returned to the Medical College and reported to the resident physician on duty that in their opinion she

had acute tonsillitis and that they suspected that she had a kidney disease also. The resident then went with them to the child's home, confirmed the diagnosis of acute tonsillitis, and treated her.

The next step was to take Edna to the out-patient department of the hospital for further studies. A diagnosis of kidney disease was established, and the child was admitted directly to the hospital. After 9 days of treatment, she was returned home for an indefinite period of bed rest under medical supervision.

In the home-care conference that followed Edna's discharge from the hospital it was decided that a public-health nurse and a medical social worker should evaluate the adequacy of her home as a place for carrying out medical recommendations, also that the services of a home teacher should be requested so that Edna would not fall behind her class.

The public-health nurse, after visiting the home, reported that Edna's aunt seemed capable of learning how to care for the child during her illness, and that she was likely to do a good job, with supervisory visits from the nurse. In order to make Edna more comfortable, the nurse obtained a hospital bed, an over-bed table, and a bed pan from the Sick Room Loan Chest, a private agency with which the Health Department contracts for renting equipment.

The home-care medical social worker learned that Edna had been living with her aunt for 2 years—ever since her mother had died. Their relationship was good, and both wanted to continue living together if some plan could be worked out for support. (The aunt's general public-assistance grant would not take care of them both.) Aid to Dependent Children was considered, but the Welfare Department found that they were not eligible for this, as the aunt, who had been reared by Edna's grandparents, was not really a blood relative. A plan under which the Welfare Department would make payments to the aunt as a foster mother was then carried out. Under this plan the home-care program was responsible for interpreting to the Welfare Department Edna's special needs and making sure of the aunt's ability to care for her.

Three months after the aunt first called on the home-care program for help, the program discharged Edna and placed her under the supervision of the hospital's out-patient department, recommending that she increase her activities gradually and that she continue studying with the home teacher. The hospital's social-service department was asked to take the responsibility for interpreting to the Welfare Department medical recommendations concerning the child.

The way in which an integrated medical-care program can work to

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Hospital care may be partly wasted unless there is a plan for continued care at home.



POINT IV AND THE CHILDREN OF THE PUNJAB

U. S. Government helps a Pakistan Province reestablish some social services for children

PAUL R. CHERNEY

IN THE PUNJAB, which used to be part of British India, but now—since 1947—is a province of the new Muslim nation of Pakistan, live many thousands of orphans—their parents killed during the bloody exchange of populations that took place at the time Pakistan separated from the rest of India. With millions of Muslims crowding into the Punjab and other parts of Pakistan, and millions of Hindus and Sikhs struggling to get away from Pakistan into the Hindu provinces, trainloads of men, women, and children were mutilated or slaughtered.

More than half the Muslims that fled into Pakistan settled in the Punjab, after remaining for various periods in its capital city, Lahore.

The resulting increase of population taxed the city's resources, as most of the incoming refugees were poor, and ill-equipped to earn an adequate income. And since the departing Hindus included many of the teachers, social workers, and those supporting children's services, these services were seriously curtailed or in many instances eliminated entirely. With thousands of children left homeless, and practically nothing done for them, it is not strange that 3,000 beggar children were roaming the streets of Lahore in 1951—three times as many as in 1938.

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He was formerly with the Children's Bureau; while on the staff of the Bureau he directed a demonstration community-organization project in Newport News, Va., and later served as Regional Child Welfare Representative for Kentucky, Michigan, and Ohio.

Mr. Cherney's previous experience in the Far East included a childhood spent in China and work in education and welfare as a military government officer in Japan.

Half a dozen years before Pakistan became a Muslim nation, the Punjab Children's Aid Society was founded by Mrs. Rameshwari Nehru, a cousin of India's present Prime Minister, to work for the protection and well-being of children in the Province, especially those who had no one else to look out for them.

The Society was established as a private organization, but was mainly supported by the Punjab Provincial Government. Its executive and most of the members of its central committee were Hindus.

The Society helped to raise standards of care in orphanages and made efforts to improve the treatment of juvenile delinquents. It provided some direct services, maintaining a temporary shelter for children, operating seven play centers, and arranging periodic outings for children in congested neighborhoods. These direct services were carried on in the city of Lahore and did not reach the rural sections of the Punjab, though the Society's constitution provides for work outside the city as well as within it. The Society also did con-

siderable groundwork for enactment of basic legislation for the care and protection of children. (This bill, called the Children's Bill, is before the Punjab Legislature as we go to press, and is expected to pass.)

When the Hindus fled from Pakistan in 1947 the Society was left without an executive and practically without a central committee. Also, the building that housed its headquarters and the children's shelter was taken over by the Provincial Government as evacuated property and was used for housing refugees.

First steps taken

For 2 years efforts to provide any services for children were at a standstill. Then the few remaining members of the Society's central committee—Muslims and Christians—set to work to rebuild the committee, and gradually it was built up to 12 active members, with Muslims in the majority. The committee members, however, were new in this type of work and knew little of what is necessary in a child-welfare program. However, the committee succeeded in en-

Syed Hasan, Chief Welfare Officer of the Punjab Children's Aid Society, examines a display of handwork at one of the play centers operated by the Society in the city of Lahore.



gaging an executive, a Muslim refugee who had some social-work training and some experience in work with children. I say "succeeded in engaging" because this man was, and is, so far as I know, the only person with social-work training in the Punjab. The municipal government of Lahore and the Punjab Department of Public Instruction gave the Society some money to operate a program, but little was done at that time.

Enter Point IV

Late in 1951 the Pakistan Government requested the United States Government to send a social worker to advise the Society on the reorganization of its services, under the general agreement for technical cooperation between the two countries. I was assigned to do this work, and I arrived in Pakistan in April 1952, to remain there till early in August.

The question then was how best to help the Children's Aid Society to serve the children of the Punjab. I was sure of one thing—that the social-work methods and techniques of one country cannot and should not be imposed on another; that social services in any place need to grow out of the concern that the people in that place feel for one another.

But I recognized also a common denominator between my own country and the one I was sent to help; it is a similarity in religious thinking

that motivates the more fortunate to help the less fortunate.

Besides, I realized that in both countries social consciousness is growing, and that this has found expression in the spontaneous efforts of private individuals and groups and in Government action to promote measures for the well-being of the people.

But like anyone else from the West who goes into a country in the Far East, I soon noticed an approach toward social problems that is different from ours.

In the Far East life is cheap; the individual is less important than in our Western culture. The social problems are so great and so overwhelming that the tendency is either to shrug one's shoulders and say that nothing can be done, or else to embark upon a mass program. Our idea of starting in a small way, of dealing with individuals, is foreign to their thinking.

Closely related to people's lack of interest in the individual is the idea that development of measures for welfare must be postponed, or de-emphasized, in favor of efforts for economic development.

Again, I found little tradition for voluntary effort. A few voluntary programs have developed, but these are exceptions. I found little spontaneous community action to meet a community problem. The tendency at

the moment seemed to be to look to the Government for everything.

I realized that efforts to improve the care of children are handicapped by the low status of women. This status is changing, but in the cities the vast majority of women are still kept in seclusion (*purdah*) and do not appear in public except with their faces covered with a *burqa*. Their activities are severely restricted, and their participation in community affairs is very much circumscribed. They have not been considered worth educating, and even now, with the present emphasis on extending education, only 15 percent of the girls of primary-school age (6-11) in the Punjab are in school, as compared with 55 percent of the boys.

Subcommittee studies the program

As the first step toward the reorganization of the Society's services, the central committee designated a subcommittee, at my request, to (1) examine all aspects of the present program, (2) study the unmet child-care needs of the community, (3) determine what services might best be provided by the Society, and (4) formulate plans for a new program to be presented to the Society's central committee.

We noted that the Society was operating the seven play centers, as it had before 1947. Only one of them had a paid supervisor. The others depended on volunteers, with unsuccessful results.

The Society had picked up again on the work with orphanages, and in the previous year the executive had visited nine of them. These were operated under Muslim auspices and appealed for voluntary support on the basis of *Zakat*, a fundamental tenet of Islam that wealth over and beyond the needs of modest living is to be used in giving assistance to persons who have been unable to obtain their share according to their needs—especially widows and orphans. The executive found that only four of the orphanages were adequately operated with regard to feeding, medical services and sanitation, recreation, and school facilities. Several of the institutions had very poor conditions, and

At a games festival, the winner of a contest is congratulated by the author of this article.



one, referred to as a "beggars' school," was closed by the Governor of the Punjab after the Society had brought its conditions to public attention.

The Society was looking forward to passage by the Punjab Legislature of the previously mentioned Children's Bill, which includes provisions for the protection of dependent and neglected children, and the Youthful Offenders Bill, which relates to delinquent children. The proposed legislation provides that the Government shall designate "a society" to carry out its provisions. If the pattern that has been established in other major cities of the Indian subcontinent is followed in the Punjab, the Children's Aid Society will be called upon by the Government to carry out the provisions of this act. In April 1952, however, the Society was not prepared to assist in setting up a program under the new legislation. (For one thing, its executive was its only staff member, other than a messenger.)

The chairman of the subcommittee, the widow of a former Deputy Governor of the Punjab, had recently been elected a member of Lahore's city council and was influential in the Muslim community. The other members of the subcommittee were two Muslims and two Christians. It was an interested and hard-working group, with almost perfect attendance at every one of the weekly meetings, which took place in May and June. This was notable in view of the temperatures of 110° to 116° which prevail in the Punjab at that time of year.

How the program stands today

The subcommittee on reorganization made a number of recommendations to the Society's central committee, and all but one were accepted. The Society began at once to put the recommendations into effect, and the present status of the program may be described as follows:

Recreation centers. Paid supervisors have been appointed in each of the seven recreation centers, part time. The pay is sufficient to interest college students. As it is impossible

to find people with training or experience in this kind of work, selections were made according to an estimate of each applicant's potentialities based on his personality, school record, and employment history. The paid supervisors help to sustain the interest of the volunteers.

Individual services to families and children. As a start in giving individualized social services, the Society has added to its staff two welfare officers, full time, to give "direct and individualized assistance to children and families who can be expected to respond constructively to such help, including financial assistance, family counseling, child guidance, and direct care of homeless children."

Shelter facilities. Children who are left without father or mother often need temporary care, and help in being placed in the home of relatives, or in an orphanage, or elsewhere. At present unattached children are exploited by bogus orphanages and by beggars and criminals, or they work as underpaid servants in private homes. There has been no facility for temporary care of children since the Society's building was taken over as a refugee center.

Therefore the Society plans to re-establish a small shelter for temporary care of homeless children. But first it is trying to work out a program for such children in cooperation with one of the existing children's

institutions with good standards. This would be done on a contract basis, and it would be considerably less expensive than setting up a separate facility. Besides, a cooperative relationship of this kind would benefit both agencies.

Recreation in children's institutions. Two relatively good institutions requested the aid of the Society in developing recreational programs. One is caring for more than 300 refugee children, the residual of some 3,500 who have been cared for and resettled by this home. The other—for the deaf and dumb—is new. The two occupy different parts of what was once a Hindu college.

The Society now employs a recreation worker who divides his time between the two institutions. Here is an opportunity for the Society to develop close relations with two important children's services. Both have resources that the Society will eventually need to call on if it is to evolve a well-rounded program.

Reorganization of the central committee. I proposed that the terms of office of the Society's officers and the members of the central committee be rotated. This would provide opportunity to different people to lead the work, and it is well known that when a person once assumes such responsibility he usually can be counted on to become a lifelong friend and sup-

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A game of "Kab-bad-di" is enjoyed by both players and spectators at the Water Works Play Center. The water works for which the center is named can be seen in the background.



WHEN A CHILD IS DEPRIVED OF MOTHERING

A Comment on Bowlby's "Maternal Care and Mental Health"

LEON J. YARROW

MENTAL-HEALTH workers agree that lack of a warm, continuous relationship with his mother or a mother substitute during a child's early years may lead to later personality disturbances.

A number of studies of the effects of depriving children of such maternal care have been reported by Dr. John Bowlby, Director of the Child Guidance Department of the Tavistock Clinic, in London, at the request of the World Health Organization. In a monograph, "Maternal Care and Mental Health," Dr. Bowlby analyzes research findings about children so deprived, and discusses the implications of the findings for social-welfare programs. First he presents evidence from research and considers its contributions to psychodynamic theories of personality development. Secondly he analyzes the social conditions that lead to deprivation of maternal care, and he makes suggestions for preventing such deprivation and alleviating its effects.

The findings are based on three types of studies: The first type includes studies of the mental health and development of children in institutions, hospitals, and foster homes, made by direct observation of these children. The second group of studies is made up of investigations of the early histories of adolescents and adults who have developed psychological illnesses. And the third class comprises follow-up studies of the mental health of children who have been deprived of their mothers in their early years.

The direct studies show clearly that children deprived of their mothers,

with no warm and loving substitute, are retarded in their language development and in their social and adaptive behavior. Dr. Rene Spitz's studies of infants in emotionally sterile institutions demonstrate dramatically the psychological—as well as the physical—impact of extreme deprivation of this kind. Other studies found the same patterns of intellectual retardation and emotional blunting in older children who had lived in institutions over a period of years.

Life histories studied

The retrospective studies review a great deal of evidence based on the histories of adolescents and adults who were treated in psychiatric clinics or brought before juvenile courts. A common background factor in one group of persons, who were called by Bowlby "affectionless characters," is a history of being placed in an institution very early in life, or otherwise being separated from their mothers or mother-substitutes. The outstanding characteristic of these persons is an inability to establish genuine, warm human relationships.

The follow-up studies tend to support the general findings of the direct and the retrospective investigations.

W. Goldfarb, who has contributed

the major share of the studies, summarizes concisely the chief effects of deprivation in early life on the personality. The children brought up in institutions, he finds, "present a history of aggressive, distractible, uncontrolled behavior. Normal patterns of anxiety and self-inhibition are not developed. Human identifications are limited, and relationships are weak and easily broken. . . . Finally, the fact that personality distortions caused by early deprivation are not overcome by later community and family experience must be stressed. There is a continuity of essential traits as late as adolescence. If anything, there is growing inaccessibility to change."

From a research point of view, it would have been desirable to analyze critically the methodological limitations of these studies. Such an analysis would point up the need for better designed and more carefully controlled studies to clarify or elaborate on the significant nuances of these early relationships that lead to emotional or personality disturbances.

The sheer mass of evidence in support of the basic thesis that extreme emotional deprivation in infancy results in personality disturbances is overwhelming. It should be empha-

What is believed to be essential for mental health, says Dr. John Bowlby, is that the infant and young child should experience a warm, intimate, and continuous relationship with the mother (or permanent mother-substitute), in which both find satisfaction and enjoyment.



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sized that the majority of the studies are based on circumstances of extreme deprivation resulting from prolonged stay in an institution. For practice as well as for basic theory, we need research on the effects of less extreme deprivation, as well as critical studies of the extent to which subsequent favorable experiences can overcome or mitigate the effects of very early traumatic experiences.

Bowlby does not distinguish sharply between the effects of separation, of deprivation, and of institutionalization. The experience of separation—a break in the continuity of the mother-child relationship—can be differentiated from that of deprivation. Deprivation essentially involves a lack of warm mothering either by the mother herself or by a substitute. Institutionalization may involve both separation and deprivation, but may be different from either in that there is prolonged absence of a consistent mother-figure.

None of the studies gives any clear evidence on the highly significant question for adoption practices—that of the age at which separation from the mother is most damaging. Most of the studies suggest that the second half of the first year is the critical period; some indicate that separation during the first 6 months is equally traumatic. The basic hypothesis that needs further testing is whether the crucial age is that at which the child has begun to identify himself with a mother-figure. We need to consider also how individual differences among infants may influence the degree or nature of personality damage.

Another significant question is: What is the effect on the child of the kind of mothering he has had before being separated from his mother or mother-substitute? If a child receives "warm mothering" before the separation, this, of course, may increase the severity of his immediate reactions. Still, one might hypothesize that the loving relations that existed between mother and child in his early life might provide the child with a foundation for forming new close relationships, and thus lessen the probability of later damage being

done to the child's personality.

Bowlby, of course, recognizes the need for further research, and is currently engaged in such research. In the November 1951 issue of the *Courier of the International Children's Center* (Paris), Rosenbluth, Bowlby, and Roudinesco offer suggestions on some of the factors to be considered in further studies on separation. ("Separation from the Mother as a Traumatic Experience for the Child: Some Notes on Obtaining a Relevant History.") Some of these factors are the age of the child at separation, the length of the separation, the quality of the mother-child relationship before separation, and the quality of the substitute mothering. In evaluating the effects on the child of the separation experience they suggest as significant observations: The child's initial responses to separation (screaming, regressing, fretting, withdrawal, depression), his later adjustment as the separation is prolonged (quality and degree of discrimination of new relationship in environment), and his reactions when reunited with his mother.

In the light of the evidence, Bowlby develops in some detail recommendations for foster care, adoption practices, and hospital care of children. He advocates that sick children, whenever possible, should be cared for at home. If a child is hospitalized, he recommends that the mother be allowed to remain with him in the hospital. If a child is to be adopted, Bowlby recommends the adoption as soon after birth as possible. While maintaining firmly that the "right place for a child is in his own home," Bowlby recognizes that in certain situations care outside of the home is necessary. He feels this should be undertaken only as a last resort, when it is impossible to make the home fit for the child.

This work will certainly have an impact on social-work practice. Beyond its application to the immediate problems with which it is concerned, it represents a significant contribution by demonstrating the close interdependence of psychological theory and social-work practice.

HOME-CARE PROGRAM

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guard the physical health of a child whose mother is sick, and to protect both from too much emotional shock caused by separation is shown in the story of Bobby S, 9 years old.

Bobby's mother had felt increasingly ill ever since her husband was admitted to a mental hospital, 6 weeks before. At last she telephoned the home-care office. The medical students who visited her diagnosed pneumonia, and reported this diagnosis to a resident physician, who went to the home and confirmed the diagnosis; he also raised the question that Mrs. S. might have tuberculosis, and recommended X-ray studies.

Next, arrangements were made for Mrs. S to talk with a medical social worker about making plans for Bobby in case the X-ray studies established the fact that she had tuberculosis and needed hospitalization.

Mrs. S was taken to the hospital in an ambulance for the X-rays. But before being admitted to the hospital for treatment, she was taken home in an ambulance so that she could explain to Bobby what was happening, and could tell him that she would have to stay away from him for some time, and why. This kept him from being frightened by her absence.

The medical social worker arranged with a children's agency to find a foster home where Bobby could stay until his mother could return.

Mrs. S was treated in the hospital for pneumonia and later was transferred to a tuberculosis sanitarium.

Since Bobby had been exposed to the danger of catching tuberculosis from his mother, the doctor arranged with a public-health nurse to see that he received adequate and continuous health supervision, including regular check-ups at the hospital chest clinic.

Thus, through the home-care program, not only were the mother's medical needs fulfilled, but her mind was set at rest by the knowledge that her boy was well cared for. Bobby was benefited through the thoughtful and sensitive action of the doctor who saw to it that the mother had the opportunity to prepare the little boy for the necessary separation.

It is not remarkable that a program set up to give good home medical care, with consideration of social factors, can evaluate the total needs of chronically ill patients treated over long periods of time. It is more difficult, and probably more important from a preventive standpoint, to find and deal with the problems of patients and their families seen only once or twice for minor illnesses.

The majority of children seen by home-care physicians have diseases such as measles and upper-respiratory infections. Despite the fact that these diseases usually require only two or three medical visits, it is frequently possible for students and residents to learn to recognize symptoms of serious medical and social pathology in these visits. The home-care program is often the means of introducing patients and their families to other community services which may be helpful in the future. A child whose heart murmur was discovered by a medical student, a family whose landlord refused to repair the plumbing, and a mother who obviously preferred one child to another were all referred to appropriate agencies in the course of visits requested for treatment of measles.

Although the agencies that helped to solve these problems were available in the community where the problems were found, it is unlikely that these families would have known of these agencies or would have seen the need for their services without the help of the home-care program. It is certain that many medical and social problems are thus discovered and dealt with before they reach serious proportions.

In conclusion it may be said that many medical and social problems of children in economically underprivileged families can be found and treated in a program operated by a health department and a medical school. Many other children may benefit, as the future patients of medical students and resident physicians trained in the program. And all the children in the city should benefit from growing up in a healthier community.

Reprints in about 6 weeks

PUNJAB

(Continued from page 83)

porter. This, however, was a new idea to the committee, and it was not possible for all of them to accept it, and so action on the proposal was postponed.

Finances. For several years the Society had been spending less than the amounts granted it by the Provincial Government, and a surplus had accumulated—enough to finance the new program for almost a year. Soon, however, more money will be needed. And I recommended that it would be better if the Society sought funds not only from the Government but also from voluntary contributors. This would bring more people into direct contact with the work of the Society—a result that might benefit the program even more than the actual funds contributed. At present, though some persons are contributing to help care for orphans and for other worthwhile causes, many give only to beggars.

I suggested that a committee of influential men and women be organized to make an annual appeal to the community on the basis of *Zakat* and charity to support the part of the Society's program that helps widows and homeless children.

What of the program's future? It seems to me that this depends largely on what can be done to obtain professional training for social-work personnel. Some steps have been taken toward making such training available. In the fall of 1951 the trustees of Punjab University authorized establishment of a committee to consider ways and means of establishing a diploma course in social work. Co-operative relationships have been established between the United Nations technical-assistance program and the Pakistan Government to assist Punjab University and Pakistan in establishing facilities for this course.

If the Society can carry out its program successfully, this will be a most important step toward integrating children's services. The recreation centers are strategically placed to reach the locations where child-care needs are greatest. They should in-

fluence the adults of the neighborhood to take more responsibility for improving neighborhood conditions that affect the well-being of the children and also to bring to the attention of organized services the problems that cannot be met by the people unaided.

The individual counseling service just getting under way will focus on the child as an individual and will concentrate on strengthening his family. This approach will emphasize that almost every threat to the well-being of child and family is many-sided and that help should be drawn from several different facilities—from health service, from school program, from economic and employment aid, and so forth. It is the responsibility of the welfare officer to seek out and use these different resources in dealing with problems of families and children.

Whether the program can be carried out will depend on the skill and understanding of the personnel. Ordinarily professional training is required to develop the skills essential for such work. Up to now such training has not been available in Pakistan but, as I have indicated, is now being started under the sponsorship of the central Government. The members of the new staff have been carefully selected and show great promise, and we expect that they will soon obtain the professional training that they need.

The significance of the Punjab Children's Aid Society reaches far beyond the size, scope, and variety of services that it will be able to undertake in the immediate future. If its new program is successful the Society's efforts will mean much more for child welfare than they do now. But we shall note the significance of its work in the extent to which it can demonstrate the effectiveness of the scientific approach in alleviating social problems, in arousing community interest, and in obtaining widespread participation in and support of social work for children. Its success will depend on how much it contributes to the development of a coordinated community program of services for the care of children.

FOR YOUR BOOKSHELF

YOUR CHILD CAN BE HAPPY IN BED; over 100 ways in which children can entertain themselves. By Cornelia Stratton Parker. Thomas Y. Crowell Co., New York. 1952. 275 pp. \$2.95.

Not only parents, but professional workers caring for sick or convalescent children, will bless Mrs. Parker for the practical suggestions given in this book.

"What can be done to bring happiness to a small patient feeling none too physically fit, and time lying so heavy on his hands?" The author answers this question with hundreds of tested ideas. She gives detailed—and lively—instructions for such things as modeling, papier-mâché work, doll-making, and weaving. She outlines amusements according to age periods, beginning with "around 1 year"; going on to "by 15 months"; then "by 18 months"; and so on, up to "9 and 10." She itemizes toys according to the child's age, with approximate prices; story books, again by age periods; book catalogs; information on children's magazines; and recipes, such as for modeling materials and for finger-paint.

But this is much more than another "what-to-do" book. It is a guide, based on knowing how children develop and on using this knowledge for keeping a sick child happy.

Marion L. Faegre

IN THE NEWS

Juvenile delinquency. Many additional national organizations with widespread membership have expressed to the Children's Bureau and the Special Juvenile Delinquency Project their interest in the campaign against juvenile delinquency. Three recent meetings brought large groups together in New York and Washington to discuss the problem of delinquency and to work out ways in which they might cooperate in the current campaign to improve community services that treat children for delinquent behavior. The meetings were of health agencies, educational organizations, and civic groups.

The first of these meetings was held on October 15 in New York under the sponsorship of the National Health Council. The member agencies of this Council met to study some of the specific implications of children's delinquent behavior so far as

the health services are concerned. Dr. Martha M. Eliot, Chief of the Children's Bureau, and Bertram M. Beck, Director of the Special Juvenile Delinquency Project, explored the problem with the organizations represented and asked them to seek out ways in which, through their existing programs, the health agencies could contribute to the over-all objective of improving services for delinquent children.

In Washington, on November 12, a meeting jointly sponsored by the Office of Education and the Children's Bureau brought together a number of prominent individuals, educators, and representatives of about 15 national educational organizations that are concerned about the problem of juvenile delinquency. The American Red Cross and the National Institute of Mental Health also sent delegates to this meeting. In their discussion of the problem of juvenile delinquency as it affects schools, the representatives pointed out a number of specific needs:

(1) School programs should be evaluated to see if each child is getting the sort of teaching from which he can profit. (2) Teachers require better training to be able to recognize signs of approaching delinquency—it was believed in-service training might be stressed. (3) Many communities lack the social and clinical services to which schools might profitably refer children having difficulty in personal adjustment. (4) Good consultative services within the school or the community could aid schools in helping children and might also be used for teacher training.

The group felt that all State members of the national organizations, including the various member groups of the National Education Association, should receive full information about the delinquency problem, and that meetings should be held to discuss the campaign against increasing delinquency. It was recommended that the NEA issue a special pamphlet explaining the problem and suggesting what could be done about it.

The third and largest of these three meetings was that of representatives of about 30 major civic organizations—fraternal, religious, veteran, educational, and professional. They met in Washington on November 17-18. The group heard the delinquency situation described—as it is today and as it may be tomorrow—by people who work in the field: A policeman, Captain Mary Ganey of Washington, D. C.; a detention-home director, Dr. Preston Sharp of Philadelphia; a juvenile-court judge, the

Hon. Alfred D. Noyes of Montgomery County, Md.; a training-school superintendent, Charles W. Leonard of Illinois; and the director of a State community-service program, Douglas H. MacNeil of New Jersey.

Representatives at the meeting stressed the necessity for developing public understanding of the problem of juvenile delinquency, and of creating public awareness that something *can* be done to help delinquent children become well-adjusted and law-abiding citizens. A number of people at the meeting thought that their national organizations would undertake to inform all their local groups about the size and importance of the problem, ask them to look into their local situation, and then encourage them to take appropriate action, along with other interested groups, toward improving their local situation. The groups will also work at the State level in cooperation with the various State planning bodies for children and youth. Some of the national organizations, it was reported, have already worked out plans for working toward the Delinquency Project goals during the coming year.

CALENDAR

Jan. 9-10. American Group Psychotherapy Association. 10th annual conference. New York, N. Y.

Jan. 17-18. United Service for New Americans. Annual meeting. New York, N. Y.

Jan. 19-30. Population Commission, United Nations Economic and Social Council. 7th session. New York, N. Y.

Jan. 21-24. Council on Social Work Education. 1st annual program meeting. St. Louis, Mo.

Jan. 24-29. American Academy of Orthopaedic Surgeons. 20th annual meeting. Chicago, Ill.

Area conferences, National Child Welfare Division, American Legion:

Jan. 9-10. Area D—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin.

Feb. 6-7. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, West Virginia.

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Pp. 81, 82, 83, courtesy of the author.

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THE CHILD

FEBRUARY 1953





nearly 4 MILLION

NEW CHANCES

to fashion a Nation of healthy, wholesome, and wise citizens

VITAL statisticians have not yet been able to count every last one, but they think the number of babies born in 1952 topped all previous records. Nearly 4 million were born.

With each new year, the chances

grow better that babies will survive the threat of illness and death from diseases. They grow better, too, for older children. But they are still far from even for all children.

Just keeping alive of course is not good enough. Our goal for every child is buoyant good health and the chance

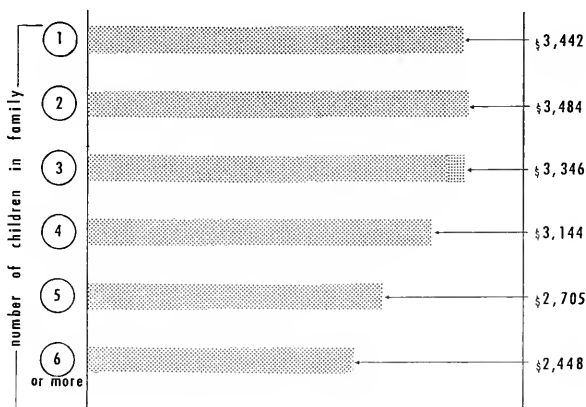
for him to grow equally well in social and emotional health. Here, too, the chances are unequal.

These pages picture a few of the yardsticks we have with which to measure differences in opportunity for children, and to point up our unfinished business for them.

BIGGEST FAMILIES HAVE LOWEST INCOMES

The Nation's children are concentrated in a small proportion of its families. Over half its 47 million under 18 belong to 16 percent of its families. These are the families with three or more children. Families with one or two children under 18 make up 40 percent of the total. The rest are families with no children under 18. Families with the most children usually have the lowest incomes. The median income for all families in 1950 was \$3,319.

One out of every 10 families is headed by a woman. In 1950, families headed by a woman had an average income of \$1,922.

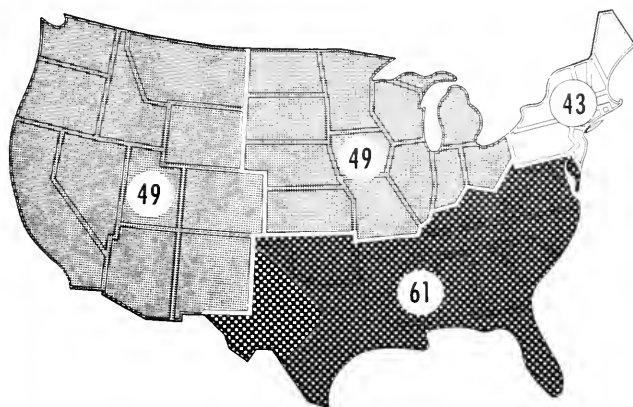


Median family incomes, 1950

ABOUT CHILDREN

AND CHILDREN'S SERVICES

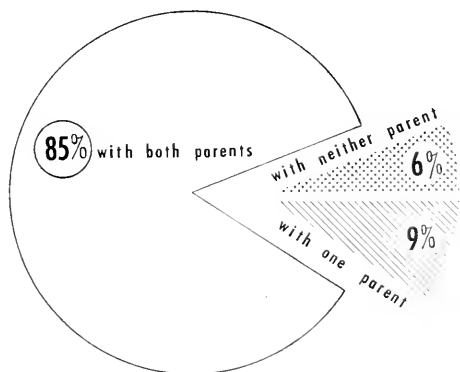
as seen by the Children's Bureau



Number of children under 18 for every 100 adults of working age, 1950

REGIONS RICHEST IN CHILDREN
HAVE LOWER INCOMES

Regions rich in children have proportionately fewer adults to support both children and the schools, the health, welfare, and other community activities that serve children. These regions have lower per capita incomes, too. In the South, for instance, South Carolina, with 74 children under 18 years for every 100 adults of working age (18 to 64 years), had a per capita income of \$838 in 1950. At the other extreme, in the Northeast, New York, with 40 children per 100 adults of working age, had a per capita income of \$1,875.



The home of 1 out of 7 children lacked one or both parents in 1950

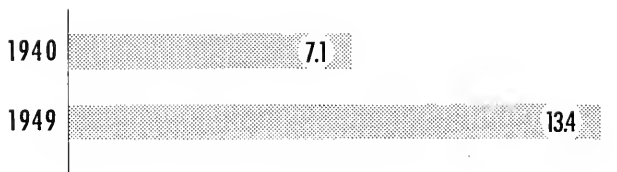
MANY CHILDREN LIVE IN BROKEN HOMES

Nine out of every 100 children under 18 years of age live with one parent only; 6 live with neither parent. Among the more than 4 million children with one parent, some 1,700,000 have a widowed parent; 900,000 have a divorced parent; 1,500,000 have a parent living away.

Divorces, down from their peak figure of 610,000 in 1946, are estimated at 371,000 for 1951. Family breakups put great strains on children, as well as parents, that sometimes can be reduced when skilled workers are at hand to help.

MANY INFANTS ARE BORN OUTSIDE MARRIAGE

Children born to unmarried mothers are in special need of help. First, the mothers should have assistance before, during, and after childbirth. In 1940, 89,500 babies were born out of wedlock. By 1949 the number had swelled to 133,200. In 1940, the rate of illegitimate births was 7.1 for every 1,000 unmarried women 15 to 44 years of age. By 1949, the rate was 13.4. In that year 30,000 of these unmarried mothers were 17 years of age or younger.

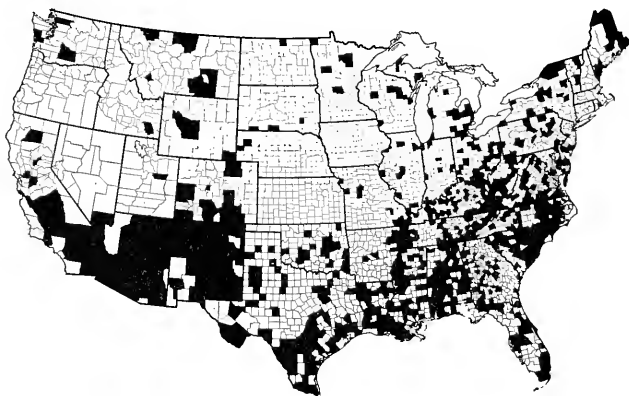


number per 1,000 unmarried women 15-44 years of age

Number of illegitimate births

INFANT MORTALITY IS TOO HIGH IN MANY PLACES

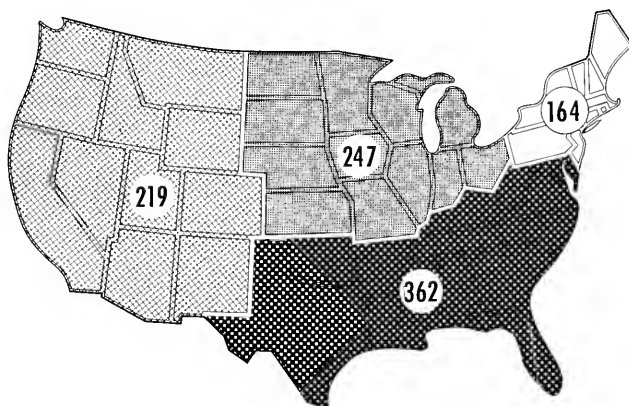
A larger proportion of babies now reach their first birthday than ever before. In 1950, the U. S. infant mortality rate was 29 for every 1,000 live births. Ten years earlier the figure was 47. Still, many babies die who need not die. If the record of infant lifesaving in the years 1946-49 had been as good in the shaded counties, mostly rural areas, as it was in metropolitan counties (where the death rate was 29.7), 50,000 babies would have been saved. Over 180,000 babies born in 1949 had no medical attendance at birth.



Greatest gains can be made in these counties

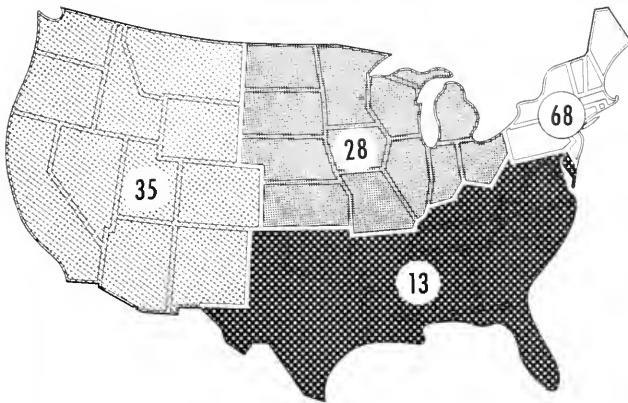
MORE HEALTH CARE OF CHILDREN IS NEEDED

Only the very old are sick more often than children. While deaths from many serious communicable diseases are all but wiped out, these diseases still occur often among children. Other types of sickness also occur often. However, doctors, nurses, hospitals, and clinics tend to center in cities and towns; specialists, in big cities. Children in isolated counties, in low-income families, and those with dark skins stand the poorest chances for health care in this country. In the whole country, there are 232 children under 18 years for each physician.



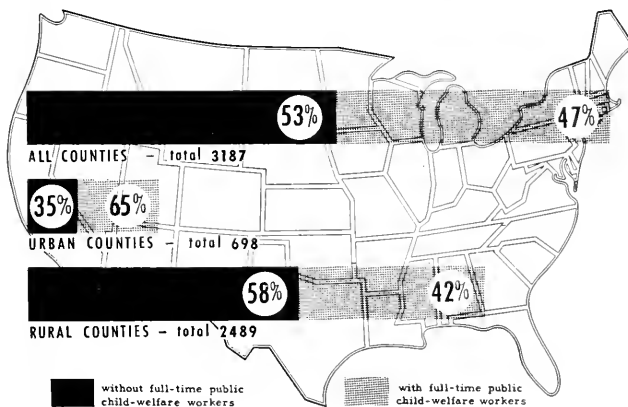
Number of children under 18 for each physician

MENTAL-HEALTH SERVICES ARE HARD TO FIND



Out of any 10,000 under 18 years, these numbers of children attend psychiatric clinics

FULL-TIME PUBLIC CHILD-WELFARE WORKERS ARE TOO FEW



1,695 counties have no full-time public child-welfare workers

In June 1951, in this country, 4,465 full-time public child-welfare workers were employed through local, State, or Federal funds. The great majority of these were caseworkers working directly on the problems of children. These caseworkers were available to children in less than half our 3,187 counties. Some counties without full-time public child-welfare workers used the services of general public-welfare workers (mostly public-assistance workers) who gave part time to children. Most caseworkers in voluntary agencies are in urban areas; few in rural areas. Rural areas, if served at all, are usually served by public child-welfare workers.

PARENTS have primary responsibility for providing the daily care and opportunity for growth that every child should have.

To plan wisely, they must know what children require for physical, emotional, and social health. They need facts from skilled and objective investigators and reporters, and guidance from persons especially trained in child development, education, health, and welfare.

Parents must have at hand, ready to use when needed, a broad range of facilities and services that no family, rich or poor, can of itself supply. Good schools, libraries, and churches; good playgrounds and recreation facilities; good hospitals, clinics, and health services; these are only a few of the community aids to a healthy, happy childhood.

Children who have lost their parents, or whose parents are unable to

fulfill their responsibilities, have always had a special claim for help.

Children in the United States are, in many ways, much more fortunate than the children of many lands. Our ideal, however, of a secure, wholesome, and invigorating personal, family, and community life for every child, from birth throughout his growing years, is still far from achievement.

TO BETTER CHILDREN'S CHANCES

the Children's Bureau works with public and private agencies,
professional workers, civic groups, and parents

THE Children's Bureau, as authorized by the Congress and the Federal Security Administrator, operates under two directives.

The first, to investigate and report "upon all matters pertaining to the welfare of children and child life among all classes of our people," comes from the 1912 act creating the Bureau. Under this act the Bureau studies many types of conditions affecting the lives of children; provides data and makes recommendations to improve practice in child-health and child-welfare service programs under the Social Security Act; helps to establish standards for the care of children.

The second of its directives charges it with the responsibility of making grants to States to "extend and improve" services for promoting the health and welfare of children, especially in rural areas and in areas of special need. This is contained in the Social Security Act, first passed in 1935, and amended in 1939, 1946, and 1950.

1. Helping parents and citizens generally with facts about children's needs which the Children's Bureau gathers from its investigations.

2. advising with workers and agencies serving children on methods and standards of care,

3. administering grants to States to strengthen State and local child-health and child-welfare services—

these are the three broad fronts on which the Bureau serves the children of the Nation.

The progress it can make, year after year, must be measured against its resources of persons and money. In 1952 the Children's Bureau had a staff of 244 workers and an operating budget of \$1,585,000.

For children's health and welfare

Title V of the Social Security Act established the principle that all the people of the United States, through their Federal Government, share with State governments responsibility for helping to provide community health and welfare services that children need.

When this act was passed, the first full year's authorized grants totaled \$8,150,000. Under the 1950 amendments, the total that may be appropriated in any one year is fixed at \$41,500,000. Actual appropriations

for the fiscal year were \$31,500,000. Of this total, \$12,524,100 was for maternal and child-health services; \$11,385,500 for services for crippled children; and \$7,590,400 for child-welfare services. The great bulk of it pays salaries of doctors, nurses, medical social workers, nutritionists, dentists, physical therapists, child-welfare workers, and other professional workers for children. Some is used to help increase the number of trained workers by granting stipends to promising candidates for training in various professional fields. Most of the money for crippled children pays for medical, hospital, clinic, and convalescent care. Some of the child-welfare money helps to pay the cost of foster care for children who cannot be cared for at home.

All States, with one exception, and the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands receive grants-in-aid for all three of these programs. (The one exception is Arizona, which, at present, does not receive Federal grants for crippled children's services.)

Each State receives a flat amount, specified in the Social Security Act, for each of the three programs. The balance of the Federal funds is

Helping young couples learn more about their expected baby is part of the maternity care given by public-health nurses in many States.



Members of the staffs of State and local health departments helping large numbers of mothers to keep their well babies



apportioned to the States on the basis of various factors that reflect the size of the child population and the State's resources for meeting the needs of its children.

To receive funds, State agencies present plans for spending Federal grants that meet the requirements of the Social Security Act and that assure good quality of services. These plans are approved by the Children's Bureau.

To take full advantage of the grants for maternal and child-health services and for crippled children's services, each State must match part of its Federal grant.

To take advantage of the child-welfare funds, each State must assume some of the cost of services in rural areas, although no fixed amount of Federal funds must be matched.

Of course, no State is limited in the amount of its own money that it spends for children's services. Indeed, many States spend a great deal more of their money than the amount needed to match Federal funds.

So long as States meet the requirements of the Social Security Act, they are free to use Federal funds in the way they think best. As a result, no two State plans are alike. This is one of the great strengths of these grant-in-aid programs. They respect and preserve State and local initiative.

In planning their programs, State agencies consult with voluntary agencies and groups on what services are needed, so as to avoid duplication and to encourage good teamwork between public and voluntary agencies.

States themselves decide which children may get the benefits of Federally supported services, under certain general policies laid down by the Federal Government. The staff of the Children's Bureau is available to State agencies to help them in planning and strengthening their services.

Types of services

Most of the services provided by State and local health departments for mothers and children are health-promotion services; that is, they are designed to help well mothers and children keep well. Typical health-promotion services are: prenatal clinics; child-health conferences; immunization services; health services for children of school age. Some States also provide medical care for pregnant women and for premature infants, but this is done in a limited way for relatively few. All States use some of their funds for the training of professional personnel needed to provide these services.

In their programs for crippled children, all States provide diagnostic services. Within the limits of their funds, all States pay for skilled treatment for some children. This may include medical care, hospitalization, and convalescent care. Children most generally helped are those needing orthopedic or plastic treatment. But most States do something also for children with other handicapping conditions, such as rheumatic fever, cerebral palsy, epilepsy, and hearing defects.

Child-welfare services are social

services for children. They are usually provided by social workers who have some special training or experience in child welfare. These workers help parents with social and emotional problems that affect the well-being of their children. The first effort of a child-welfare worker is to keep the family together. But if the problems are such that its children are neglected, or emotionally disturbed, or show other adverse effects, it may be necessary, for the protection of the children, to remove them from their homes. When this happens, child-welfare workers help to make other plans for the care of such children, either in foster-family homes or in institutions. They place children for adoption when it has been determined that a child must be permanently removed from his own home. They find family homes or day nurseries for children whose mothers work outside the home. They help children who get into trouble with the law, and work with agencies dealing with such children. They help unmarried mothers, and babies born out of wedlock. They work with citizens and agencies in improving State laws on adoption, guardianship, and support, and in building better community conditions for children. In a limited way, they give help to mothers receiving assistance for dependent children under the Public Assistance program.

Pages that follow report on recent developments in children's services aided by Federal funds.

crippled children's agencies hospitalize 43,000 children a year, they provide care at clinics for more than four times as many.

To find welcoming families like this for children without homes is one of the many big jobs that State child-welfare workers are doing.





School health



Speech therapy



Homemaker services

SOME CHILDREN ARE WINNERS

IN THE past decade and a half, during which the Social Security Act has been in effect, many hundreds of thousands of children have benefited through the provisions for maternal and child health, for crippled children, and for child welfare.

The numbers served under these State-Federal programs in 1951, as made available through reports from the States, are shown in the table on the next page.

In that year, the number of expectant mothers attending prenatal clinics approached 200,000. Almost 400,000 babies were brought to well-baby clinics. Well over half a million children of preschool age attended well-child conferences.

In the same year about 230,000 children received care under the crippled children's program.

Under the child-welfare program in 1951 more than a quarter of a million children received child-welfare casework service, the largest proportion of them in foster homes.

Every State, of course, has its own individual approach to problems concerning children's well-being, according to its resources and the conditions in the State. Here are a very few examples of the work done in the various States for maternal and child health, crippled children, and child welfare:

MATERNAL AND CHILD HEALTH

More and more State health departments are joining with hospitals and medical schools in developing

community services for the care of premature babies. And they are understanding better what a financial burden premature birth places on a family.

In order to reduce complications of pregnancy, which cause many premature births, several States that have been active in caring for premature babies are giving greater emphasis to prenatal care, and to planning for medical and hospital care for women with complications of pregnancy.

Sixteen State health departments are helping families to pay the costs of medical and hospital care for a limited number of such infants.

In several States—California, for example, the health department joins with a medical school's department of pediatrics to bring a well-trained pediatrician into rural areas regularly, so that he can provide consultation services to the doctors in these areas. More arrangements like this would greatly improve the care of children.

A number of State health departments, especially in the Southwest, have been joining with their State departments of education to develop better health services for children of school age. Arkansas, for instance, has a "pilot-school health program." This means that several schools, in different parts of the State, have been developing a complete health-education program in their own

localities. These serve as examples to the other schools in the State, suggesting what can be accomplished when all a community's services for children are focused on the schools in the interest of the children's health. Each summer key personnel from the pilot schools meet to review the programs.

CRIPPLED CHILDREN

State crippled children's agencies are continuing to broaden their programs to include more kinds of handicapping conditions, and are experimenting with new types of services.

Perhaps the most notable example of these is the rapid development of clinic and hospital care for children with congenital heart disease. Many States that have the specialists needed to care for children with congenital heart disease are including such children under the regular crippled children's program.

In order to diagnose and treat children who live in States that do not have this type of medical and surgical experts, regional centers have been established in three States—Connecticut, to serve some of the New England States; Illinois, to serve 12 States in the Midwest; and California, to serve Far Western States, as well as Alaska and Hawaii. Two more centers—in Maryland and Texas—are beginning work.

The importance of a child's hearing and speech, in school and in later life, is recognized by many States,

and their concern has been gaining momentum.

Tennessee's State Health Department has joined with the Tennessee Speech and Hearing Foundation and Vanderbilt University to develop in Nashville a speech and hearing facility for diagnosis and treatment. Tennessee's legislature has appropriated \$120,000 for each of 2 years—fiscal years 1951-52 and 1952-53—in order to develop a State-wide speech and hearing program that includes hearing tests and speech evaluation throughout the schools. When further diagnosis and treatment are needed the children are referred to the speech-and-hearing center.

A center for the hard-of-hearing has been established in Houston, Tex. The District of Columbia now offers crippled children's services to children who are hard of hearing. California has virtually completed plans for a speech-and-hearing center in Los Angeles, to which children may be sent by the MCH and CC programs for complete study and treatment. In Arizona a hearing program is being developed in cooperation with the schools and other agencies, aimed at early discovery of children with hearing impairments and provision of medical treatment and corrective therapy, as well as adjustment of their educational programs.

Although programs for children with epilepsy have not developed widely as yet, the States have shown increasing interest in them. Utah, Maryland, Iowa, and Illinois have set up special programs for such children; and a number of other States are working out plans for epilepsy programs.

CHILD WELFARE

Reaching children before their troubles become so serious that they must be removed from their homes is a major objective of the child-welfare programs. Both public and voluntary agencies are trying to do this through providing social services to children in their own homes.

Some States (notably Alabama, California, Florida, and New York) are studying the relation between the

child-welfare program and the Public Assistance program for Aid to Dependent Children, and methods of providing social services to children in families receiving Aid to Dependent Children.

Interest in homemaker services as part of a program for the social, emotional, and physical well-being of children is growing. Under this plan, a social agency selects women chosen for their skills in homemaking and their ability to work with children and to adjust to various situations, and places them in homes where children lack their mother's care because of her death or illness. Councils of social agencies are trying to extend or develop this type of service in Worcester, Mass.; Dallas, Tex.; San Francisco and Los Angeles, Calif.; Toledo and Dayton, Ohio; South Bend and Richmond, Ind.; and others. Several States have initiated homemaker service as part of their public child-welfare programs.

Development of protective services for children who are neglected or abused by their parents continues, especially in Denver, St. Paul, St. Louis, and Chicago.

A number of States have strengthened standards for licensing foster-family homes, child-placing agencies, and children's institutions. Public and voluntary agencies are helping foster parents, and cottage parents and other staff members in children's institutions, to provide better care for children. The number of children in foster-family care has increased in many communities, but the need for additional foster-family homes is still urgent.

Widespread public interest in adoption continues. The Arizona Bar Association is sponsoring legislation for improving the adoption law; a civic group in Portland, Oreg., has studied the State adoption law and has recommended further legislation to improve it; California has developed State and local citizens' groups to study and foster improved adoption programs.

Many agencies are giving more attention to the need of older children for adoption as well as to placement of infants at an earlier age.

CHILDREN AND MOTHERS SERVED BY STATE AGENCIES UNDER TITLE V, SOCIAL SECURITY ACT

Maternal and Child-Health Services in 1951

Medical services

Mothers admitted to antepartum medical service	189,000
Mothers given postpartum medical examination	53,000
Infants admitted to medical service	395,000
Preschool children admitted to medical service	565,000
Examinations by physicians of school-age children	2,394,000

Public-health nursing services

Mothers admitted to antepartum nursing service	268,000
Mothers given nursing service at delivery	4,000
Mothers admitted to postpartum nursing service	279,000
Infants admitted to nursing service	677,000
Preschool children admitted to nursing service	697,000
Field and office nursing visits for school-age children	2,160,000

Immunizations

Smallpox	1,821,000
Diphtheria	1,831,000

Dental inspections

Preschool children	80,000
School children	2,466,000

Crippled Children's Services in 1951

Total, children receiving physicians' services from State crippled children's agencies (unduplicated count)	229,000
---	---------

Physicians' services

Clinic service	186,000
Hospital in-patient care	43,000
Convalescent-home care	6,000
Physicians' services other than clinic services, hospital in-patient care, or convalescent-home care	24,000

Child-Welfare Services, December 31, 1951

Total, children receiving child-welfare casework service from State public welfare agencies	258,000
In homes of parents or relatives	102,000
In foster-family homes	112,000
In institutions or elsewhere	44,000

CHILDREN IN SPECIAL JEOPARDY

CHILDREN in this country are on the whole making gains, but some groups seem to have two strikes against them.

Among these are:

1. Babies prematurely born, and babies born in places where health and medical services are poor or lacking.

2. Children of migratory agricultural laborers.

3. Boys and girls who are delinquent or in danger of becoming delinquent.

There are others, but special attention was given in 1951-52 to studying the situation affecting these groups.

INFANT MORTALITY

Special medical and nursing services are already saving many premature babies' lives; even very small babies have been saved. Even so, large numbers die. More than one-third of all the babies who die in the first year of life and 60 percent of those who die in the first month are prematures.

With some 200,000 babies a year born prematurely—at least 6 percent of all the babies born alive in this country—the main problem is not only to save these babies after they are born, but also to prolong pregnancy to normal duration.

It is now well established that women who have poor prenatal care, or none, are more likely to have a premature baby than are those who have good prenatal care.

Good prenatal care, with special care for women with complications of pregnancy, offers the greatest possibility of reducing the incidence of prematurity and thereby of lowering infant mortality.

In saving babies' lives, a question that is equal in importance to that

of prematurity is the problem of the baby—premature or full term—who is born in one of the many localities—mainly rural—where progress in providing medical services for mothers and babies lags far behind that of the Nation as a whole.

Problems connected with saving premature and other babies' lives in such localities are more than medical ones. They involve low incomes, poor sanitation, and habits of people. Needlessly high are the infant death rates among Negroes, among the Spanish-speaking, among Indians, and among migratory agricultural laborers.

These people need comprehensive help with their problems by voluntary agencies and local, State, and Federal Governments.

Such concerted action should bring to these people more doctors, nurses, nutritionists, and medical social workers who know the special problems of the group they are dealing with and can work with them effectively.

Community programs focused on saving the lives of babies in such places must, of course, be a part of the State and community health programs. They must be kept closely related to the skills of the public-health officer, the public-health nurse, and the sanitary engineer, and to treatment in doctors' offices, clinics, and hospitals. Social services may often be needed to help individual families with economic or social problems that in themselves affect the health care that can be given. Where this type of help is needed a medical-social worker or a child-welfare worker in the community may be called for.

If a local health unit is already established, maternal and child-health services should be operated in and from that unit. In areas with few or

no health facilities, additional local health centers designed to make a frontal attack on infant mortality may need to be organized.

CHILDREN IN MIGRANT FAMILIES

Children of migratory agricultural laborers are, economically and socially, the most depressed group of



Modern ways of caring for prematures save many lives; but the main problem is to reduce the incidence of prematurity through adequate care of mothers during pregnancy.

children in the United States. There are between 250,000 and 1,500,000 of these children. Too many of them are growing up without having enough of anything: enough food, adequate shelter and clothing, adequate medical care, and basic education. Sickness and mortality rates are high among them. As they follow the crops, many of these families move from one set of makeshift quarters to another, badly overcrowded, dirty, unsanitary, dilapidated.

Their problem is fundamentally an

economic one, and its solution lies in long-range social and industrial measures. But in the meantime much could be done for them.

Though in some localities these families are receiving particular attention, in others their needs are ignored. If efforts to improve their situation are to be effective, not only must the several agencies involved within a State work together, but States must work together cooperatively. Among the measures these families need are: Adequate housing; environmental sanitation; health and medical care for infants and expectant mothers; health education that

ably additional staff — physicians, nurses, medical social workers, nutritionists, health educators—will be needed to provide individual care and to make arrangements with social agencies for welfare services. In view of the poor resources these families have, provision must be made for medical and hospital care. Exchange of information between States on a planned basis would help to maintain the services.

Another constructive measure for health as well as welfare would be provision of day-care centers. Since in these families both the parents and the older children usually work,

JUVENILE DELINQUENCY

One of the most serious by-products of the general insecurity brought about by periods of international unrest—a period such as we are now again experiencing—is the marked increase in juvenile delinquency.

Adolescence is a period when youth is naturally in revolt against the adult world. In seeking their own place in the world and establishing their identity, adolescents tend to band together. They may easily fall into antisocial patterns of behavior, with which we are familiar in this country. They may also be exploited, as in totalitarian countries. Adults dare not shirk their responsibility to understand the behavior of adolescents and to help direct it into constructive channels.

Because this problem is becoming increasingly serious, the Children's Bureau during the past year gave a major part of its attention to it. It established in the Division of Social Services a newly organized Juvenile Delinquency Branch. Working closely with this Branch is a Special Juvenile Delinquency Project, financed through private contributions to the Child Welfare League of America. In cooperation with the Special Project the Children's Bureau has sponsored a series of conferences with many leaders in this field and with public and private agencies.

The Project and the Bureau have been developing material that will be of immediate practical value. Many States and communities are not clear about what kind of services they should have. The Project and the Bureau have therefore undertaken to develop standards, or statements of desirable practices, governing juvenile-police services, the juvenile court, and the training school. Specialists from over the country are, or will soon be, working on these standards. When completed, they should be useful guides in bettering services.

The Children's Bureau is also preparing material for the use of State agencies when working with their State legislatures in the organization and administration of services for children, including delinquents.



A boy in trouble with the law wonders what will happen to him. If his community has good treatment services, he will be helped to find his way to normal social adjustment.



Many children of migrant agricultural laborers grow up without enough of anything—enough food, adequate shelter and clothing, adequate medical care, and basic education.

will reach the different cultural groups.

One of the basic handicaps in providing help for migrants is the lack of coverage by local health units. Strengthening local health units should have a high priority among public-health advances. When these exist, especially in rural areas, the mechanism will be available for solving other urgent health needs.

Mobile health units may also be a useful device for putting health care within reach of these families. Prob-

ably young children are often left pretty much on their own. In a few States, day care is provided, but this type of care is sparse indeed.

State and local health and welfare departments, which have the basic organization to do the job, should take responsibility for administering health and welfare services to meet the needs of migrants. Migrants should not be set off from the rest of the population, but should be enabled to participate in all community services as much as possible.

WORKERS BEHIND THE CHILDREN

IF PROGRAMS to aid children are to be of value, they have to be manned by competent people. Even though colleges, universities, and professional schools are trying to increase the number and the skills of people competent to work with children, the demand for these workers far exceeds the supply.

For this reason one of the major uses to which State agencies put their Federal grants for maternal and child-health, crippled children's, and child-welfare services is in special training of workers. One way they do this is to help finance the cost of courses, institutes, or work groups, where doctors, nurses, social workers, and others can go for specialized training in the care of children. Another way is to use some of their Federal-State funds for stipends and tuition for people to take advanced training in some specialized area of child care.

Recently, training opportunities in such specialized areas as audiology (the science of hearing), rheumatic fever, epilepsy, and care of premature infants have been utilized more fully by the States. Persons completing the special training project in audiology at the State University of Iowa have taken positions in widely scattered States.

The 1952 rheumatic-fever work group in Connecticut was attended by medical, nursing, medical social, and administrative personnel from rheumatic-fever programs in California, Kentucky, Nebraska, New Hampshire, Oklahoma, and Washington.

The epilepsy training program in Massachusetts trained six physicians and five electroencephalographic technicians in its first 6 months.

The institutes sponsored by the New York Hospital Premature Training Project have been attended by teams of physicians and nurses from New York City, New York State, Connecticut, Florida, Maine, New Hampshire, New Jersey, North Carolina, Massachusetts, and Pennsylvania.

Additional training facilities in public-health nutrition have been set up by two schools of public health (at the University of Minnesota and the University of Pittsburgh). A number of other educational institutions are attempting to bridge the gap between the demand and the supply of nutritionists by offering for the first time a major in public-health nutrition.

A few States are providing workers with stipends for the second year of medical social work training or for an internship program in medical social work in a hospital. Special training projects in medical social work have been established by three States (Illinois, Louisiana, and Massachusetts), with schools of social work cooperating in preparing medical social workers more adequately for the maternal and child-health and crippled children's programs.

The shortage of maternity and pediatric nurses is particularly seri-

ous. Advanced programs of study in maternity and pediatric nursing have been developed in six university centers. Scholarship funds are not yet sufficient to meet the requests of many young nurses who wish to specialize in maternal and child care.

Health personnel working with mothers and children need understanding about the emotional growth and development of children. Many State agencies have been active in this field, holding work groups in child development for physicians, nurses, and other personnel, and helping medical schools provide training in maternal and child-health work. An institute for medical social workers, on growth and development of children, organized by the Harvard School of Public Health was enthusiastically received.

State public-welfare agencies are making steady progress in training and staff-development programs for child-welfare staff. This is reflected in increases in the positions established for special consultants on staff development; in the number of field-work training units developed in co-operation with schools of social work; in the amounts set aside for professional education; and in the number of States providing Federal funds for salaries of new workers during orientation before they enroll in a school of social work. Work groups and institutes, including representatives from other public agencies serving children and from voluntary agencies, are being used to a greater extent as a medium for staff development.

QUEST FOR KNOWLEDGE

FORTY-THREE years ago, the President of the United States, in urging the creation of a Children's Bureau, said this in a Message to Congress:

"It is not only discreditable to us as a people that there is now no recognized and authoritative source of information upon these subjects relating to child life, but in the absence of such information as should be supplied by the Federal Government many abuses have gone unchecked; for public sentiment, with its great corrective power, can only be aroused by full knowledge of the facts."

Two years later a Children's Bureau came into existence by Act of Congress. The act creating it charged it to investigate and report on child life.

For close to 41 years this Bureau has been gathering facts about children and ways of caring for them. Because it has always been a small bureau and the child population has, happily, been large, it has had to be selective about the aspects of child life which it studied.

Main target of its investigations through the years has been the plight of disadvantaged children: babies who die in infancy; children who are beyond the reach of good health services; infants born to unmarried mothers; children who have lost their parents or whose parents are unable to carry their responsibilities for their children; juvenile delinquents; children who go to work at too early an age and in hazardous occupations; crippled and handicapped children.

"Public sentiment, with its great corrective power," informed by these studies, has corrected many of the "abuses" that were common four decades ago. Many State laws today deal more wisely with the child who is in trouble with the law; the child who is to be adopted; the child who has been neglected or abused; the child for whom a legal guardian must

be approved by the court; the child who is crippled.

Federal laws, too, have reflected the findings of these studies. Out of the Bureau's investigations, at least in part, flowed the Sheppard-Towner Maternity and Infancy Act of the 20's—the first Federal law to put Federal funds in the hands of State departments of health for extending and improving their maternal and child-health services. In the 30's came the Social Security Act, again to strengthen State and local maternal

investigation into conditions of child employment.

At the turn of the midcentury, a year ago, the Bureau took a long look at its record of investigations. It had earlier called in experts from a wide variety of research fields to advise the Bureau on future plans. With them, the Bureau pondered at length its responsibility as the Federal Government's chief investigator of "all matters pertaining to the welfare of children and child life among all classes of our people."

Clearly the job of fact finding had not come to an end. Indeed, the pressure on the Bureau for more and more facts had grown with the years. With the establishment of the maternal- and child-welfare programs under the Social Security Act, a multitude of questions and problems arising out of the service programs had turned up for study and answer. The questions, too, had become more difficult to answer as the people concerned about the well-being of children had grown more sensitive to the emotional needs of growing human beings.

For four years the Bureau has maintained a Clearinghouse of information on research on child life conducted in universities and other centers around the country. From this, it has gathered a general view of where the answers to questions about children might be forthcoming from others.

Out of this review, the Bureau has now drawn its plan of investigations for the immediate years ahead. For the present, at least, the Bureau proposes to hold rather closely to the line suggested by its past studies, focusing its investigations on children whose health or welfare is in jeopardy. Studies of such children can add greatly to knowledge of child life in general, for they will raise and deal with questions of fundamental importance for the health and welfare of all children.

(Continued on page 103)

HOW . . . WHEN . . . FROM WHERE WILL ANSWERS COME TO SUCH QUESTIONS AS THESE . . .

How many feeble-minded children are there who should be cared for at home rather than in institutions?

Is the health of school children improving through existing school health services?

Why are some physically handicapped children able to function well socially when others, with the same handicap, cannot?

Could well-child clinics do a more effective job of preventing illness?

Which adoptions turn out well?

What becomes of children of unmarried mothers who are refused Aid to Dependent Children?

and child-health services, and to do the same for the social services children need. Behind the program of Aid to Dependent Children, provided for in the same act, were many studies made by the Bureau into the problems of mothers who had to carry entire responsibility for their children. The child-labor provisions of the Fair Labor Standards Act of the late 30's had as a forerunner years of Bureau

TEAMWORK HELPS

Cooperation with other countries

Although this Nation has large concerns in improving the chances of its own children, it realizes more and more that their well-being is affected by the well-being of children in other countries. The Children's Bureau has for years exchanged experience and ideas with children's agencies in other countries. In recent years the scope of its international program has broadened.

Under Point IV, for example, the Bureau is responsible for sending specialists to assist in establishing or improving programs of social services for children and of maternal and child health, when countries request our Government for such help. At the present time the Bureau has 12 such specialists working abroad.

Many specialists in maternal and child health and child welfare come to the United States, under various auspices or independently, to study and observe activities of public and private social or health agencies. The Children's Bureau is responsible for planning programs of study and observation for these specialists.

Many of these visitors are sponsored by the United Nations Secretariat, some by the World Health Organization, others by the Mutual Security Agency. The Department of State sponsors certain leaders from many countries, including former enemy nations, as well as visitors under the sponsorship of their own governments.

During the fiscal year 1952 programs of observation and study were planned and arranged for 66 visitors from 29 countries (in this country for periods varying from a month to 2 years); and interviews, group discussions, and brief observation for 257 visitors from 48 countries (for periods varying from a day to several weeks).

Cooperation with other Federal agencies

By May 1953 the Interdepartmental Committee on Children and Youth

will have completed 5 years of sharing information about their programs affecting the well-being of children and youth. Through this exchange, cooperative effort between the member agencies has been greatly strengthened.

The committee, which includes 35 representatives of Federal agencies and their subdivisions, has met monthly since May 1948, when it was created at the request of the President of the United States.

Much of the committee's work goes forward through subcommittees. One subcommittee, on "Research in the Federal Government on Problems of Child Life," is chaired by a representative of the National Institute of Health. Another is working on "Care of American and American-Related Children Outside the United States," under the chairmanship of a member of the Defense Department. A third, whose chairman is on the staff of the Department of Labor, is studying "Children in Families of Migratory Agricultural Workers."

Several of the committee's important problems have been discussed at seminars, at which consultants from different parts of the country contribute experience and ideas.

The first of these, held with the help of the Josiah Macy, Jr., Foundation, was developed to help the com-

mittee consider how the philosophy and findings of the Midcentury White House Conference on Children and Youth could be woven into Federal programs affecting children and young people.

Understanding and Working Together on Juvenile Delinquency was the subject of the second seminar.

The committee's most recent seminar aimed to arrive at a plan whereby all interested Federal agencies can work together in behalf of children of agricultural migratory laborers.

The committee has issued three reports: "The Needs of Children of Puerto Rico" (1950), "Programs of the Federal Government Affecting Children and Youth" (1951), and "Youth—the Nation's Richest Resource" (1953).

Among the agencies represented are: Department of Agriculture (Extension Service; Production and Marketing Administration). Department of Defense (Departments of the Army, Navy, and Air Force). Department of the Interior (Bureau of Indian Affairs; Office of Territories). Department of Justice (Bureau of Prisons). Department of Labor (Bureau of Labor Standards; Bureau of Employment Security; Wage and Hour and Public Contracts Divisions). Department of State (five subdivisions). Administrative Office of the U. S. Courts (Division of Probation). Federal Security Agency (Children's Bureau; Bureau of Public Assistance; Office of Education; Public Health Service; Bureau of Old Age and Survivors Insurance; Office of Vocational Rehabilitation). Housing and Home Finance Agency (Public Housing Administration). Selective Service System. The committee also includes a consultant from the Bureau of the Budget.

Children benefit through cooperation between nations. This mother is learning how to care for her baby through a program carried on by Pakistan's Government with the help of the United Nations International Children's Emergency Fund and the World Health Organization.



QUEST FOR KNOWLEDGE

(Continued from page 101)

Many thousands of children, for one reason or another—such as their own illness, or the death of or neglect by their parents, or their own illegitimate birth—are separated from their parents. Sometimes this separation is short; sometimes it is for life. Health and social workers are often involved in such separations and so must know how to deal with them wisely.

Because such situations may cause deep-seated difficulties for many children and because they have been studied so little, the Bureau is making them the focus of its investigations in the immediate future. At first a small study to test out research method will be made. Depending on its outcome, a broader piece of research will be undertaken in this field later.

Such questions as these will be explored: How harmful is the separation of a child from his parents? At what ages, under what circumstances, in what ways, and to what extent is it damaging? By what means can the detrimental effects of separation from parents be overcome?

To learn about delinquency

Another line of inquiry which the Bureau will pursue in the near future concerns juvenile delinquency. Out of this study the Bureau hopes to find answers to such questions as these: What different methods have been attempted to reduce the incidence of juvenile delinquency? How successful did they prove to be? Do some methods prove to be more effective with some boys and girls? Does experience point to new and better ways of treating these youngsters?

Again, this would be a pilot investigation, a gathering together of current knowledge, intended to pave the way to more comprehensive research later. This might be undertaken by some other research organization, by itself or in cooperation with the Bureau.

The whole area of parental attitudes toward child rearing presents many difficult questions crying for answers. To what extent are parents

unduly worried about how to bring up their children? Are over-worried parents found in all economic and cultural groups? How can such undue anxiety be alleviated? How successful have the various means of educating parents been in reducing over-concern in parents? Exploration of such questions is something which the Bureau cannot undertake in the near future, but it is on the Bureau's long-time calendar.

How effective is the work for children?

Like all sound business enterprises, many health and welfare agencies serving children, eager to make their time, their skills, and their dollars produce the greatest possible good for their clients, are asking for help in appraising the effectiveness of their operations. Because of their close working relations with the Children's Bureau under the grant-in-aid child health or welfare programs, some of them turn to this Bureau for advice on how such studies can be made. A part of the time of the Bureau's research staff is, therefore, earmarked for this kind of assistance. The staff is still small, however, so the amount of consultation that can be given is limited. To spread its knowledge more widely, the staff is preparing a report on methodology of this kind of research which will be shared with all interested child-health and welfare agencies.

As the Children's Bureau moves into its fifth decade of investigating and reporting, it rededicates itself to finding new or better guides to help parents and workers give all children the fair chance they should have for a useful and satisfying life.



- Feb. 2. National Children's Dental Health Day. 5th annual observance. Information from Bureau of Public Information, American Dental Association, 222 East Superior Street, Chicago 11, Ill.
- Feb. 7-13. Boy Scout Week. 43rd anniversary. Information from Boy Scouts of America, 2 Park Avenue, New York 16, N. Y.
- Feb. 8-15. Negro History Week. 28th

- annual observance. Information from the Association for the Study of Negro Life and History, 1538 Ninth Street, N.W., Washington 1, D. C.
- Feb. 15-22. Brotherhood Week. 19th annual observance. Sponsored by the National Conference of Christians and Jews. Information from the National Conference of Christians and Jews, 381 Fourth Avenue, New York 16, N. Y.
- Feb. 18-20. National Conference of Superintendents of Training Schools and Reformatories. 30th annual meeting. New York, N. Y.
- Feb. 23-25. American Orthopsychiatric Association. 30th annual meeting. Cleveland, Ohio.
- Feb. 27-28. Eighth National Conference on Rural Health. Council on Rural Health, American Medical Association. Roanoke, Va.
- Regional conferences, Child Welfare League of America:
 - Feb. 4-6. Eastern Region. Asbury Park, N. J.
 - Mar. 16-18. Central Region. Columbus, Ohio.
 - Apr. 16-18. Southern Region. Nashville, Tenn.
 - Apr. 26-28. South Pacific Region. Berkeley, Calif.
 - Apr. 30-May 2. North Pacific Region. Seattle, Wash.
- Area conferences, National Child Welfare Division, American Legion:
 - Feb. 6-7. Area B—Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Puerto Rico, Virginia, West Virginia.
 - Feb. 12-14. Area C—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama Canal Zone, South Carolina, Tennessee, Texas.
 - Mar. 13-14 (tentative). Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont.
-
- The National Midcentury Committee on Children and Youth has closed its office in New York. Inquiries may be addressed to the chairman, Leonard W. Mayo, Room 700, 580 Fifth Avenue, New York 36, N. Y.
- Illustrations:
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 - Page 95, right, New York State College of Home Economics at Cornell University.
 - Page 96, left, Public Health Service, Federal Security Agency.
 - Page 96, center, Kentucky Society for Crippled Children.
 - Page 96, right, Lilo Kaskell, New York.
 - Page 98, Virginia State Department of Health.
 - Page 99, left, Look Magazine photograph.
 - Page 99, right, Library of Congress photograph.
 - Page 102, Unations.



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THE CHILD

MARCH 1953



PARENTS LEARN ABOUT THEIR PREMATURE BABY

Hospital holds
discussion groups to help
fathers and mothers
whose baby
is born ahead of time

GELLESTRINA DIMAGGIO, R.N.
and
MARGUERITE B. GELINAS

WHEN A BABY is born prematurely in our hospital, we of the staff try to reassure the parents and help them to solve their problems concerning the baby. Some parents are afraid that they are responsible for the baby's prematurity, and sometimes one parent thinks the other is at fault. Most do not understand why a premature baby needs special care. A large number fear that the baby will be mentally retarded, or in some way marked. Many other doubts and fears plague the parents of a premature baby.

Meeting supplements hospital teaching

In the comparatively short time the mother remains in the hospital it is impossible for the staff to give the parents all the information and reassurance they need, even though the doctor, the nurses, and the medical social worker do what they can in the time available.

Since we staff members cannot help the parents as much as we should like to during the mother's hospitalization, we take a step toward helping them later. For this purpose we invite the parents of each premature baby to meet with some of us, along with a group of other such parents soon after the mother is discharged, while the baby is still in the hospital.

Before the mother goes home the

medical social worker tells her and the father about the meeting. She says that it will be held some evening within a month, at the hospital, and that three hospital staff members that the parents already know will be there to answer questions. These staff members are: a doctor (who is an assistant resident assigned to the pediatric ward); a nurse; and the medical social worker. The medical social worker points out to the father and mother that other parents may have problems like theirs, and that the various couples will have a chance to exchange ideas. She encourages them to go to the meeting and to express their views, and she helps them to formulate some of the questions they have in the back of their minds so that they can be more ready to ask them at the meeting. Lastly she tells them that they will soon receive a postal card telling them when the meeting will be held.

We find that if the postal card is followed by a personal invitation from the nurse, the doctor, or the

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This article is an outgrowth of material prepared for the eightieth National Conference of the American Public Health Association.

medical social worker, the couples invited are more likely to come. We welcome also grandmothers, aunts, and others who will be helping to care for the baby.

On the evening of the meeting the parents gather in a conference room adjoining the children's ward in the hospital, and they sit in easy chairs, in an informal circle. The doctor introduces the couples to one another and says a few words about the purpose of the meeting. He then goes on to tell the parents some of the facts about prematurity. Now and then during the doctor's talk the nurse and the medical social worker (the present writers) raise questions that we know some of the parents wish to have answered.

Prematurity explained

The doctor explains what happens when a baby is born prematurely and tells what is known about the causes of premature birth. Then he makes clear why the baby must be kept under special care in the hospital until he has developed sufficiently to be taken home like other babies, and he points out the great importance of gain in the premature baby's weight, which shows that he is becoming more mature—more like a full-term baby.

Explaining the purpose of incubators, he tells about the special precautions that must be taken when a baby is in an incubator.

The special hospital care, the doctor goes on, brings the baby through



A nurse shows how she holds a premature baby in her arms while giving him feedings.

the crucial period after premature birth by providing, so far as possible, the protection he would have had if he had remained in his mother's body for the full term. The doctor helps the parents to see that when they take their baby home they can treat him just like a full-term newborn baby.

The doctor explains why the baby needs to be followed up by an ophthalmologist. The explanation is presented to the parents as a precautionary measure even though only a very small percentage of babies develop retrolental fibroplasia, an eye condition associated with prematurity.

When the doctor is through speaking, he asks the nurse to tell a little about the care that the nurses give to a premature baby and to offer the parents some suggestions on caring for the baby after he is taken home.

The nurse tells the parents that a premature baby needs much more attention when he is little than does a full-term newborn baby, and that the smaller the baby the more nursing care he needs. She says that the very small baby, who needs incubator care, remains in the incubator as long as his body temperature is unstable and as long as he needs to be given

oxygen; later he will be placed in a little crib. When he is very small, she goes on, he is too weak to suck, and is fed through a tube or with a medicine dropper while he lies in the incubator. Later, when he is strong enough to suck, a nurse holds him in her arms and gives him his feedings from a nursing bottle.

She encourages the parents to come in during the baby's last few weeks in the hospital to visit, hold, feed, bathe, and get acquainted with him, explaining that when the baby is ready to be discharged, he has been receiving for a week or two the regular baby care that the mother herself will give.

The nurse tells the group that a day's supply of formula will be given the family on discharge. A discussion usually follows as to the type of formula that will be needed and how to prepare it at home.

Many questions asked

Questions that parents frequently ask the nurse are: When can we take the baby outdoors? What should be the temperature of the baby's room? Can we open the window? May the baby have sun baths? Do we have

to give any particular care to the baby's clothes? Can we use commercial diaper service? What kind of skin care should the baby have? Is a flexible schedule suitable for premature babies?

She explains also that some one on the hospital staff will ask the visiting nurse to look in on the mother and baby in the home a few times to be sure that everything is going well. This is not because we expect any difficulties, but because we feel it gives a sense of security to the mother and helps bridge the gap from hospital to home for the baby. The parents are glad to have this help; as a rule they have already been visited by the nurse before they attend this meeting. They know who she is, remember what she has discussed with them, and realize that she will help them to prepare the home for the coming of the baby and that she will visit the baby after he is discharged from the hospital.

During the nurse's talk the medical social worker and the doctor ask questions as a step toward amplifying some of the points she brings up.

After the nurse finishes, the medical social worker talks with the group of parents about various questions, most of which the parents have already mentioned to her. Most of these questions revolve around six topics:

1. Why was this child premature?

One young mother attributed the premature birth to the fact that she washed a floor once during pregnancy. After the baby was born her anxious husband told her that he would be boss during the next prenatal period.

2. What can be expected of the growth and development of a premature baby?

One father was sure that the child would be an idiot. He could see the child was well formed, but he felt that some major mark of prematurity must remain.

3. Is there danger of overprotecting the baby because he is premature?

The word "premature" is discussed, and emphasis given to what may hap-

pen if the parents continue to think of the child as being premature after he has reached the stage where his development is going along at a normal pace.

4. How should the other children at home be prepared for the homecoming of the premature baby?

What the parents have already told the other children is discussed, as well as what the other youngsters expect this baby to look like when he is brought home, since he may be smaller than they expect.

5. What are the feelings of the parents themselves about not having had the baby at home with them during his long hospital stay, and how

Some parents feel that this baby may be more fragile than their other children were or that they may expect too much of him during his period of growth.

In the discussion, individual members support and stimulate one another. Sometimes a shy mother will speak up when the parent next to her asks a question bordering on one she herself has in mind.

We have learned the value of recognizing the parent who might be a good discussion leader. If this parent's interest is stimulated he or she may be able to initiate discussion around particular points.

Often intelligent, articulate par-

want to know. They must be given an opportunity to express their doubts and fears. The discussions at the meetings show us where each couple needs help most.

Most of the parents come to only one meeting, though a few come to the next one if their child is in the hospital for more than a month. Parents seem to get enough help from one group session to enable them to work more effectively with the medical social worker, the doctor, and the nurse on the ward if the premature baby is still in the hospital, or with the visiting nurse if he is already at home.

Attendance at the meetings varies greatly. Usually only three or four sets of parents attend. The number seems to vary according to how many premature babies are in the hospital and the time of the babies' stay there. We feel that the attendance is also related to the spacing of the meetings. In the future we hope to reach more parents by having the meetings every 3 weeks instead of once a month.

It may also be true that the parents of a premature baby who is already at home may not feel they need to attend the meeting if things are going well with them and with the baby.

Most of the parents feel that these meetings are helpful to them; they feel that we are interested in them as well as in the baby; and in talking with other parents face to face they realize that they are not the only ones who have questions about their baby.

The help given at the meeting, according to many parents, makes their adjustment to their baby easier.

We have found the program extremely valuable in helping parents give better care to their premature babies. We are examining the procedure and seeking methods of improvement. This has been an interesting experience for all of us and one that we hope has contributed to the care of premature babies in general.

Reprints in about 6 weeks



This premature baby is just as well-developed as a full-term newborn baby, after completion of his special hospital care. His parents were not worried, for hospital staff members had helped them realize that the baby would soon catch up with normal development.

might their feelings affect their care of the baby during the post-hospitalization period?

This question is closely related to the feelings of guilt that some parents have when they imagine that they have done something during the mother's pregnancy that might have brought on the premature birth—or that they have neglected to take some necessary precautions.

6. Might the parents feel insecure in caring for such a small baby?

ents who have had a previous premature baby are present. Such parents can speak from experience and can supply concrete examples of some of the problems involved in the care of these babies. They can also describe their methods of solving those problems.

The staff assisting with the meetings has learned a great deal. We have seen that a simple explanation to the parents about prematurity does not necessarily tell them all they

SOCIAL AGENCIES CAN IMPROVE STAFF TRAINING

ALICE L. TAYLOR

FOR HALF A CENTURY, particularly in the last 15 years, the social-work profession has been talking about the preparation of social workers and who should be responsible for it. We are still saying many of the things that we have said in the past, but two important steps have been taken toward clarifying the problem and solving it.

One of these is the completion of the Bureau of Labor Statistics survey, "Social Workers in 1950" (published by the American Association of Social Workers, 1952). This report gives, among other facts, the number of workers in various positions in social-work agencies and their education and experience. The facts are sobering, because they point out serious lacks in the educational status of the profession.

The other step was taken when a new national body, the Council on Social Work Education, was formed in 1952. The Council represents not only graduate schools of social work and agencies employing social workers, but also undergraduate colleges, professional social-work organizations, and the general public. Under the Council's constitution, the agencies assume a share of the responsibility for developing policies, principles, and programs for education in social work. The other groups repre-



Experience, based on professional education, enables a social worker to develop her skills in helping people. These skills can be developed further through in-service training. Members of the Council also share in this responsibility.

As a result of these two important happenings we now have not only some facts on which planning for social-work education can be based, but also a broadly representative body to lead and coordinate this planning.

As a base from which to plan, both for preparing new social workers and for giving additional training to those

already employed, let us look at the total number of positions in social-work agencies in the United States. In June 1950 this number was 75,000, the Bureau of Labor Statistics study shows; and only one-sixth of the people in these positions had had the two years of graduate study in social work that is now generally accepted as professional preparation for a social worker.

These figures give us a rough idea of what social workers lack in the way of professional education. But we cannot be sure that the figure 75,000 represents the upper limit of the number of social-work positions for which educational planning needs to be considered.

Why is it not necessarily the upper limit?

1. Because no comprehensive study has been made to determine what each

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This article is condensed from a paper Miss Taylor gave at the seventy-ninth annual meeting of the National Conference of Social Work, held at Chicago.

of these 75,000 positions requires with regard to knowledge and skill.

2. Because we do not know how many additional social workers will be employed in established social-welfare programs, or in new social services, or in the social-work programs of organizations that are not primarily social agencies. Additional social workers may be employed by the public-health services and by large private medical-care programs. They may take positions with labor unions and industry; they may join the staffs of public schools; and they may enter the international field of social work.

3. Because more than 40 percent of these 75,000 positions are in public-assistance work, the need for which should decrease as more people are covered by social insurance and as insurance payments to individuals become more adequate. Thus, we do not know how many staff members will be necessary in order to serve the people still needing public assistance. Again, we do not know what qualifications will be required of these workers nor of those carrying social-work functions in insurance programs.

Since we cannot know how various factors will affect the number of social workers needed, we must, for the time being, consider 75,000 social-work positions as a basis for planning improvements in professional preparation.

At the same time we recognize that the distribution of workers among programs and the qualifications required in the various positions may shift with continued movement of workers, with more knowledge about the specifics of practice, and with refinement of our professional knowledge and skills through research.

The Bureau of Labor Statistics figures, of course, can give us little on quality of service and individual competence. Social work differs from professions like law and medicine, whose practitioners are licensed as competent to practice. To identify a social worker who is professionally qualified, a social agency depends upon the amount and kind of education he has and on his membership in professional organizations, based on educa-

tional requirements. In a public agency the merit system may delineate further qualifications required of the social worker.

The social worker practices, not on his own, but within the structure of agency administration, policy, philosophy, and supervision, all of which are subject to review by the community; for example, by a board or a council of social agencies, or through legislative study, or through a licensing procedure, as in a child-welfare agency. Although social workers hold themselves individually responsible as professional people, they should recognize the importance to the public interest of the supervisory structure within which they operate.

The community depends for protection upon the agency's upholding the quality of its service through selection of qualified staff, through administrative standards, and through supervision and continuing development of staff on the job.

In view of the lack of full professional preparation of five-sixths of the workers already employed by social agencies, as shown by the Bureau of Labor Statistics report, and the many changes occurring in the field, it is clear that some practical steps need to be taken by the agencies toward improving the training of their workers.

We are generally agreed that agencies have two goals in staff development: The first is to get the agency's

work done effectively. The second is to help each employee, trained or untrained, to keep abreast of the field and to develop as he carries out his part of the work. These two purposes are not to be looked at as primary and secondary purposes, but rather as associated goals.

Survey figures point to need

There is no doubt that all agencies, particularly the public social services, have urgent responsibilities for staff training. The needs of the public services are especially clear from figures in the survey showing that governmental workers at the State and local level have had the least education and experience.

Also, the fact must be faced squarely that for years to come the agencies will have to operate with a number of untrained workers. This points to the need for a study of agency practice to determine which jobs require professional training as a "must."

An agency in the long view should aim at engaging persons with a college degree as a minimum educational requirement. This is important, particularly as the degree is one requirement for admission to a school of social work, and the worker may later be given educational leave to enter such a school.

For older, untrained workers who have demonstrated ability and capacity for growth, on-the-job training will continue to be the chief measure

A child welfare worker helps a child and his foster parents better when her natural ability and her training are backed up by good agency supervision and continued in-service training.



by which their competence can be improved. Refresher opportunities should be provided by the agency to keep workers up to date. With social workers at an average age of around 40 years, we would indeed be a discouraged profession if we believed that only young persons can continue to learn.

Since good supervision is the key-stone of an agency's constant efforts to improve the work of its staff, let us look at the qualifications of the more than 6,000 supervisors of caseworkers and group workers reported in the Bureau of Labor Statistics study.

In State and local tax-supported agencies as a whole—including public welfare agencies, courts, hospitals, and others—just over half the supervisors had had some graduate social-work study; another fourth reported some other type of graduate study, or a bachelor's degree but no graduate study. Only about one-sixth had had two years or more of graduate social-work study.

In the private agencies almost four-fifths of the supervisors reported some graduate social-work study, and 54 per cent had had two years or more of graduate social-work study.

We see that the supervisors in the private agencies had more professional education than those in the public agencies. But even in the private agencies only a little more than half the supervisors had had the two or more years of graduate social-work study now accepted as the professional education needed by a social worker. Yet the supervisors are responsible for teaching other workers on the job through the supervisory process.

The supervisors were an experienced group. About three-fifths of them reported 10 or more years of social-work experience of various types; only 10 per cent had had less than five years. Experience is exceedingly important in developing competence and expertness, but experience needs to be based on professional education.

Whatever the content of the job, if persons in supervisory positions are to teach staff and otherwise give

leadership in social work, they should be well equipped with social-work knowledge and skills. I shall refer to this later in discussing the steps that agencies should take in staff development. If individuals and communities are to receive the social services they need, social agencies need to pay special attention to the number and qualifications of supervisors, their salaries, and the distribution of qualified supervisors among the various services.

Share responsibility for training

Let us turn for a moment from the number and qualifications of social workers to the significance of agency membership in the Council on Social Work Education.

The Council recognizes that—

1. Social-work education is the responsibility of the whole profession—educators, practitioners, membership organizations, social agencies, and regulatory bodies.

2. The public has a stake in the kind of social-work education that is provided, as this determines largely the nature and caliber of services in the community.

How do these principles affect agencies that employ social workers?

Over the years, selected social agencies have been contributing to social-work education by providing field work for students from schools of social work. Most agencies have followed some plan for training their own staffs.

But do agencies realize what it will mean to share fully, through the Council, the responsibility for social-work education? It will mean that if the agencies are dissatisfied with the products of social-work education, they can no longer complain without doing something about it. The agencies must share fully in a long-range plan to improve the preparation of social workers.

Since under the principles agreed upon, the agencies have a voice in formulating educational policy and plans, they will be expected also to contribute to carrying out these policies and plans. How can the agencies best do this during the next few

years? I present several suggestions, which concern study of agency practices, financial support, exchange of personnel between schools and agencies, and staff development within the agency, particularly the training of supervisors.

Social agencies should find ways to take part in establishing and carrying out a profession-wide study of agency practice, to include analysis both of social-work concepts and of social-work jobs. Such a study would help point out more clearly the role of social work in the community and the nature of the qualifications required in each of the 75,000 social-work positions.

This tremendous undertaking is essential if we are to be clearer about what should be taught in agencies and in schools. The agencies should carry a full share of responsibility in this kind of project as the next important study among the many areas of social-work research that await doing.

To contribute to such a project, agencies will need to give their staffs time to work, in groups or individually, toward clarifying concepts and methods and to designate or prepare materials identifying these. This kind of activity will contribute directly to improving curriculum content.

The need for a study of practice is already under consideration by national organizations closely related to practice, such as the American Public Welfare Association, the American Association of Social Workers, and the National Social Welfare Assembly.

Agencies can contribute to the study of practice in many ways.

An agency might study, for example, the relation between the social workers' job and jobs of other professional persons, a relation about which there is still a good deal of confusion. This relation has been highlighted in the international field through increasing emphasis on teamwork between social workers and, for instance, public-health nurses, and on the domestic scene, between social workers and clinical psychologists.

Efforts need to be made, also, to answer questions that have arisen as to the social-work content in public-

assistance work and the specific knowledge and skills needed by administrators and consultants in large public welfare and health programs.

Delineation of social-work function may come more easily if tackled first in the better-defined and long-established fields such as child welfare or medical social work.

In placing a child, for example, the responsibilities of the social worker, the judge, the doctor, and the psychologist are fairly specific.

Medical social work, which has clarified its functions in relation to doctors, nurses, dietitians, and other hospital personnel, could well carry this on by further delineation of the broader medical social work functions in large public welfare and health programs. In fact, the Federal Security Agency's Children's Bureau has begun preliminary exploration of this subject with medical social consultants from State maternal and child health and crippled children's programs. The Bureau of Public Assistance is also engaged in this type of study, focusing it on the social-service components of Aid to Dependent Children.

Again, agency studies to clarify concepts, principles, and processes of administration in the public social services would help in curriculum revision to strengthen courses in administration and public welfare. Curriculum study by the American Association of Schools of Social Work has indicated need for such improvement. Local, State, and Federal agencies, which have developed and improved administrative practice in the last 15 years, have much to offer curriculum.

Discussion of agency responsibility for the study of content of social-work practice leads to a second area in which agencies should contribute to staff development directly and indirectly.

Faculties of schools of social work, as well as agency personnel, need refresher opportunities. Faculty members need more time for research and greater opportunity to keep in direct touch with agency programs in order to distill from practice the principles of professional education. This will

keep social-work education abreast of the needs of the field and thus will contribute to the competence of agency staffs.

Agencies should consider ways to provide opportunities for faculties to participate more directly and continuously in practice. This could be done by inviting faculty members to attend conferences on policy formulation, to join in special agency training sessions, to help develop—or to carry on—research projects, and to participate as temporary employees in the day-to-day work of the agency during the nonteaching semester or while on sabbatical leave. Participation in these activities would contribute both to agencies' administration and to faculty development and would help to clarify the areas of content that should become a part of the curriculum.

Another example of a desirable two-way flow between the agency and the school is the opportunity for qualified agency staff to teach, on request, in schools of social work.

To plan in-service training

This kind of exchange between the agency and the school, and on-the-job training of staff as outlined below, will require that agencies designate a portion of the budget for educational purposes. Agencies should consider, also, ways to stabilize this part of the budget, so that educational planning can be done on a long-range basis, say 5 to 10 years.

Extended use of such educational funds to strengthen the qualifications of staff on the job should be considered. This may well be done:

1. By establishing a well-balanced staff-development plan and a clearly written policy to carry it out, including orientation, adequate supervision, educational leave, and use of supplementary resources.

2. By assigning the staff-training function in large agencies to a special position, and in small agencies specifying clearly its place among related functions.

3. By making staff training an integral part of the program.

This requires conviction about staff

development. Such conviction must be expressed concretely by giving the training function an equal place in policy making, side by side with other functions. It also must be made real by giving training functions the same administrative and financial support as agencies provide in budget and staff allocation to other agency responsibilities, such as public relations, statistics and reporting, legislative and program planning, and fiscal matters.

4. By considering plans for educational leave. If the agency pays salaries, tuition, and travel costs to permit staff to obtain basic or specialized training, or refresher courses, depending upon the agency's needs, this will make formal professional education possible for workers.

To improve its supervisory group, for example, agencies should develop objective criteria for potential supervisors, spot such people within the agency, and give them opportunity to learn to supervise. This will involve practice in supervising others while receiving supervision. Developing skill on the job on a planned basis is essential. Such a program may well require special educational-leave planning for this group. This kind of staff training cannot and need not wait on analysis of practice.

Schools also should consider their part in supplementing agency resources for development of supervisors. Supervisors need to be well equipped as professional persons, regardless of the breadth or intensive nature of services or program content supervised.

I have not attempted to provide the answers to even one of the many complex problems in development of staff. My suggestions will be validated or discarded and the answers found only as the four groups represented in the Council for Social Work Education—the agencies, the schools, professional organizations, and the general public—work together nationally and in local and State communities. Development of staff is not the responsibility of agencies or schools alone. It must be a shared responsibility.

Reprints in about 6 weeks

RACE PREJUDICE AND CHILDREN

KENNETH B. CLARK

RACE PREJUDICE damages the children of the dominant group as well as children of the minority group against which the prejudice is directed. As minority-group children learn about the inferior status to which they are assigned—as they observe the fact that they are almost always kept apart from the dominant group, who are treated with more respect by society as a whole—these children may react with deep feelings of inferiority and a sense of humiliation. They lose some of their self-esteem; they become doubtful about their personal worth. Like all other human beings, they need a sense of personal dignity; but almost nowhere do they find their dignity as human beings respected.

Under these conditions it is inevitable that the minority-group child is thrown into a conflict that affects not only his attitudes toward himself but also his attitudes toward his group. "Am I and my group worthy of no more respect than we get?" he asks. And thus the seeds of self-hatred and of rejection of his own group are sown.

These children need to find some way in which to deal with their confusion. The way in which a given child resolves this basic conflict depends upon many interrelated factors. Among these are: the cultural and historical background of his particular minority group; the social and economic class of his family; the stability and quality of his family relations; the cultural and educational background of his parents; his own personal characteristics, intelligence, special talents, and personality pattern.

Not all minority-group children react to racial rejection with the same patterns of behavior. Some children,



Not all children are learning to build up prejudice against persons of minority groups.

usually of the lower socio-economic classes, may react by overt aggression and hostility, directed toward their own group or toward members of the dominant group. Then the larger society may not only punish the children concerned, but may interpret their aggressive behavior as justification for prejudice and segregation. Thus the cycle is perpetuated.

Middle- and upper-class minority-

group children are more likely to react to their racial frustrations and conflicts by withdrawn and submissive behavior. On the other hand, they may compensate by rigidly conforming to the prevailing middle-class values and aggressively determining to succeed in meeting these values in spite of the handicap of their minority status.

Many children, however, of various social and economic classes, react with a generally defeatist attitude and a lowering of personal ambitions. These children tend to be hypersensitive and to be anxious about their relations with the larger society. They see hostility and rejection even where they do not exist.

Undoubtedly a pattern of personality difficulties results when any human beings are placed in an unjust and unreasonable social situation. Although the specific aspects of this

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This article is excerpted from a paper presented by Dr. Clark at a meeting of the National Urban League, in connection with the seventy-ninth meeting of the National Conference of Social Work, held in Chicago.

pattern do not hold for every child in a rejected minority group, and although the range of individual differences among members of such a group is as wide as among other peoples, the evidence suggests that all these children are in some ways unnecessarily harmed by discrimination against them.

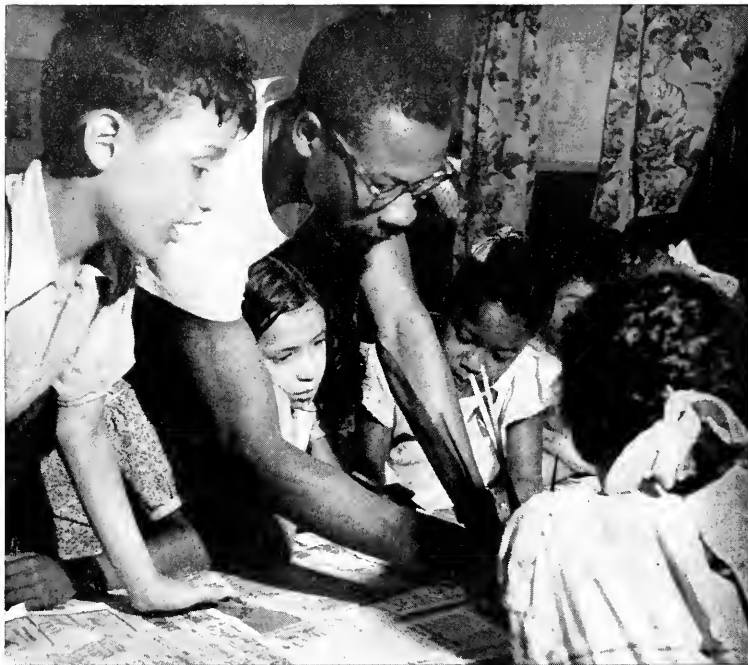
The effect of race prejudice on the personalities of children of the dominant group is more subtle and somewhat more obscure. These children are supposed to benefit from the system of differentiated status. It is *their* position that allegedly is being safeguarded against the encroachments of the "inferior" peoples. They stand to gain in economic and social status. How then can we say that such a child's personality is damaged by the very system that seeks to offer him such advantages? How is it that the advantages gained through race prejudice interfere with the development of healthy personality in the children of the dominant group?

The children of the dominant group who are required to adopt the prejudices of their society are taught to gain status at the expense of the status of others. They are not expected, when comparing themselves with members of a minority group, to evaluate themselves in terms of the basic standards of personal ability and achievement.

Our culture permits them, and at times encourages them, to direct their feelings of hostility against whole groups of people. These children learn to fear and hate the rejected minority peoples. They develop mechanisms to use in an attempt to protect themselves from recognizing the injustice of their behavior toward the minority group.

Teaching may be contradictory

Children who are being taught race prejudice at the same time and by the same persons and institutions that teach them the moral, religious, and democratic principles of the brotherhood of man and the importance of justice and fair play are likely to become confused. It is clear to children of average intelligence and higher that there is a contradiction



To be effective in an interracial agency a worker must understand basic human values.

between adults' race prejudice and their moral teachings. When this contradiction is imposed upon children, it may become a personal problem that demands personal attempts at solution. Some may try to solve the problem by intensifying their hostility toward the minority group. Others may react with feelings of guilt, which are not necessarily reflected in more humane attitudes toward the minority group.

A serious reaction to this moral and ethical conflict brought about by race prejudice in an ostensibly democratic society is the development of a pattern of moral cynicism, through which some of the children of the dominant group attempt to relieve themselves of disturbing moral pressures. Such children react by repudiating the right of their parents and other authority figures to offer any moral guidance. They excuse their own egocentric behavior by developing a pseudo-sophisticated philosophy of life, expressed as "The strong should dominate the weak"—"Every man for himself"—"Get what you can while you can."

Other children may attempt to resolve this conflict by assuming a rigid and uncritical acceptance of the rightness of their parents and other authority figures. These children tend to idealize all authority figures, such as their parents and strong political and economic leaders. They despise the weak, while they obsequiously and unquestionably conform to the demands of the strong.

Understanding of the effect of race prejudice on the lives of children of different groups has encouraged the idea of combating such prejudice through the medium of the interracial social agency.

More and more social agencies are being recognized as an effective force in bringing about social change. But it would be too much to expect that all the workers in this or any other field have escaped the many personal and social manifestations of race prejudice. The corroding effect of such prejudice is seen in the fact that many social agencies exclude from their benefits the members of minor-

ity groups who are most in need of help. Others accept a token number of such people in order to appease their feeling of guilt and to satisfy the vestige of their social conscience. Some have strict quotas as to the number of minority-group persons they will help.

Should develop out of needs

This fosters development of agencies dealing exclusively with a particular minority group. Many agencies dealing exclusively with Negroes reflect the community pattern of segregation; and, what is even more serious, they tend to perpetuate it.

An agency that seeks to help the members of a minority group to break down the barriers of segregation needs to develop a pattern of constructive interracial activity and personnel. A truly interracial agency that works effectively in reducing the economic and psychological racial pressures upon the Negro is difficult to find.

An interracial agency cannot be imposed upon the Negro community by detached, impersonal whites, no

matter how good their intellectual motives, and be effective. To be effective the agency must develop out of the real needs of the people whom it intends to serve. It must be a result of the cooperative efforts of truly mature people who recognize these needs and are able to work together as human beings in an attempt to meet them realistically.

A genuinely successful interracial agency will not indulge in the transparent maneuver of having a token number of individuals of one or the other group in a professional capacity, or a token number of clients of either group.

One should not fall into the trap of thinking that a strong and effective interracial agency can be built by choosing personnel of different races primarily in terms of race and with little regard for the qualifications of the individual and the degree to which these are appropriate to the job that he will be required to do. A strong agency must have qualified people. To have an unqualified Negro in a position in order to demonstrate that an agency is "democratic" does

not help society, the agency, or the Negro. There are an increasing number of Negroes who are qualified and who can be evaluated by the standards used to evaluate whites. Either positive or negative use of a double standard of judgment represents race prejudice.

The personality demands upon the individuals who attempt to work together in an interracial agency are great. These demands cannot be minimized for either the whites or the Negroes. The work will require the highest level of maturity of personality that is attainable in our culture today. Only truly developed human beings can work with individuals of a different race with mutual respect.

Mature personalities needed

It is to be expected that some whites, who eventually might be quite effective in a joint social-action program, will at first bring to their attempts to work with Negroes the residue of past stereotyped ideas, condescending and patronizing attitudes, and at times naive and oversentimental ideas. On the other hand, many Negroes show their discomfort in an interracial situation by self-righteous posings, by aggressiveness, and by hostile hypersensitivity concerning the intentions of whites. If an interracial agency is to make an effective contribution to our society, the individuals of both groups must rise from these infantile levels of reaction to a more mature one.

An individual, white or Negro, who seeks to function successfully in an interracial agency cannot be status-conscious, since such agencies generally do not have high status. If an individual can find personal security only in rigid conformity to conventional, middle-class values, he is not likely to be an asset to such an agency.

Furthermore, a white worker who is still struggling with the elementary problem of unresolved racial guilt feelings, and who expresses this struggle by "loving" all Negroes or constantly proclaiming his freedom from prejudice, is likely to arouse the suspicion and resentment of Negroes and thereby reduce his effectiveness.

(Continued on page 117)

Race prejudice injures not only the children of rejected minority groups, but all children.



MENTAL HEALTH IN CHILD REARING

LEO KANNER, M.D.

IN THE past few decades considerable stirring has taken place among psychologists, educators, and psychiatrists concerning the factors responsible for adequate personality development in children.

We have seen a stage in which rigid rules and regulations were handed to parents in order to assure what seemed to be optimal nutrition and "habit conditioning" for the child. This pediatric perfectionism and behaviorist mechanization of child rearing tended, perhaps unintentionally, to lay down the law and to treat such auxiliaries as the clock and the scales as major factors in bringing up children.

Parents sometimes confused

Now that we recognize the significance of parent-child relationships in the child's development, we no longer set up commandments requiring certain procedures in child-rearing, but rather emphasize the effects of parental attitudes. However, I believe that the literature—both professional and popular—has put too much stress on injurious parental attitudes and not enough on affection, acceptance, and approval.

As a result, many parents have been made uneasily self-conscious about their influence on their children. The whole modern development has somewhat too abruptly taken away from parents the age-old sanctions that they had received from centuries of "Mother knows best," "Children should be seen and not heard," "Spare the rod and spoil the child." Those were the days when discipline was interpreted as "breaking a child's will." There was no room for doubt. It was clearly parents' obligation to teach children to submit unquestioningly. For the children's future safety, any tendency toward nonconformance had to be nipped in the bud. Surrender by the



child was "good" behavior, and anything less than surrender was "bad" behavior.

Now, however, instead of feeling under obligation to fit their children into a prescribed mold, parents have grown to feel—with considerable justification—that these are secondary in importance to something that we call, more or less vaguely, the child's happiness, security, or emotional comfort. A generation or two of parents has had to relearn, to shift from coerciveness to guidance.

Hence we have a mixture, puzzling to parents, of age-old tradition and relatively new ideas—a mixture that impinges differently on different parental personalities. The mature, secure, genuinely accepting parent has little difficulty in adjusting to the newer ideas because they blend easily with his or her own needs.

The newer ideas lift from the parents the pressures which earlier,

against their nature, had pushed them toward a repressive kind of child rearing.

Rejecting, perfectionist parents can find great comfort in pooh-poohing the "newfangled" ideas and can find sanctuary in the pronouncements of pediatricians and psychologists who still believe the old ways of child-rearing are best. Overprotective parents can seek solace for their agitations in the scary type of pseudo-preventive ideas which are poured upon them, lava-like, from frightening books—now fortunately decreasing—from advertisements, from the lips of neighbors, and even from some medical peddlers of gloom.

We are now in the middle of the twentieth century, which Ellen Key, the Swedish sociologist, called "the century of the child." In the first half of these hundred years, with the help of various branches of science, we have come to an understanding of the needs of children, both physical and emotional. There is still much to be learned, but a certain number of basic principles have emerged, which, even after the disappearance of ephemeral fashions, should stand the test of time.

We have learned the simple truth that any child has a good chance for satisfactory mental health, regardless of physical condition and I.Q. and other circumstances, if he can from

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This article is based by Dr. Kanner on a paper that he prepared for the Midcentury White House Conference on Children and Youth. The paper is one of a number that served as resource material for the Fact Finding Report of the Midcentury White House Conference on Children and Youth. The procedures of the conference did not provide for official approval of these papers. Address inquiries to the chairman, Leonard W. Mayo, Room 700, 550 Fifth Avenue, New York 36, N. Y.

the beginning of life feel that those closest to him like him, want him, and accept him as he is. We have also learned that it is not only severe cerebral and endocrinologic disorders that can work havoc with the mental health and adjustment of human beings; personality and behavior disorders can also result from the attitudes of parents who are markedly rejecting, disapproving, exploiting, perfectionistic, overprotective, or overpossessive.

We have not quite learned how to translate this knowledge into terms that would lead it to become as thoroughly accepted by parents as is, for instance, the knowledge that children should be vaccinated against smallpox or that cleanliness will prevent many forms of physical illness. Such acceptance is difficult because many individuals are too emotionally involved in the older ideas of child rearing to accept the newer ones.

To restore parents' self-confidence

There will always be parents who will need individual guidance, and this, we hope, will be offered them through an expanding number of child-guidance and mental-health units all over the country. Nevertheless much will be gained if we can present to the public simply stated truths, which can eventually become an integral part of our culture and that of future generations.

Because of progress in the sciences dealing with human beings, we have taken away from parents the certainty, the complacency, the assumed omniscience, the power that was theirs in generations past. We have thus made parents self-conscious in their role as parents, have made them groping and jittery. We have produced a generation of parents who wail: "It is all our fault, but what can we do?" It is therefore our solemn obligation, which we shall not and dare not evade, to restore to parents a comfortable modicum of self-reliance, poise, and composure and to provide a basis for self-confidence that is different from the authoritarian rigidity that underlay it in the not too distant past.

Reprints in about 6 weeks

RACE PREJUDICE

(Continued from page 115)

Equally ineffective is the Negro who is constantly demanding of whites absolute freedom from all forms of prejudice or the one who seeks to curry favor with whites by obsequious and fawning behavior.

The individuals of each group must be people of integrity. They must have an understanding of basic human values. And they must be clear about their common human and social goals. In short, they must be so clear about the relation between their joint struggle for racial justice and the larger goals of strengthening the foundations of American democracy for all people, that they are not likely to become ensnared in racialism even as they are allegedly fighting for racial justice. It should be clear that they are in a joint fight for human equality, decency, and justice. This, I believe should be the basic philosophy of the staff, the board of directors, and the contributors to an effective interracial social agency.

Fortunately, the days of the Lady Bountiful approach to social services have gone. The modern world demands that the field of social work become a dynamic instrument in the process of social action. Intelligent planning of the curriculum in schools of social work will have to take into account the fundamental social changes that are taking place in our society. These schools must play a positive role in preparing their students to take an active part in social action beyond the more restricted community programs.

Social workers must be prepared to help individuals live more effectively in a changed world—a more democratic world. Social workers must be prepared to help people mobilize their strength to help in the attainment of a more democratic world by democratic means.

In order to do this a social worker must be clear in his own values. He must understand the need of all human beings for that dignity and integrity which is the essence of humanity.

Reprints in about 6 weeks

IN THE NEWS

A child adopted in a foreign country by American citizens can now be naturalized on the petition of his adoptive parents without being readopted in this country. This is provided by an act of Congress that became effective December 24, 1952 (Public Law 414).

Previously such a child could not be naturalized before he became 18 years of age unless a decree of adoption had been issued for him in this country.

Under the present law, before a child adopted in a foreign country can be naturalized he must have been admitted to the United States for permanent residence; must have been adopted before he reached the age of 16; and must have resided continuously in the United States in legal custody of the adoptive parent or parents for 2 years before the petition for naturalization is filed, though only 1 year of the child's physical presence is required.

The present law applies not only to children adopted after the law became effective but to children adopted previously.

Under the former law children of some racial origins were not eligible for citizenship, but under the present law any child is eligible who is admitted to this country for permanent residence. Thus a Japanese or a Korean child adopted abroad by American citizens can now be naturalized. **Population.** The number of children in the United States under 18 years old increased more than twice as fast as the total population between April 1, 1950, the date of the last census, and July 1, 1951, according to estimates released February 11, 1953, by the Bureau of the Census, Department of Commerce. On July 1, 1951, there were 48,585,000 children under 18, compared with 46,724,000 on April 1, 1950—an increase of about 4.0 percent. During that 15-month period, the total population in the United States increased from 150,697,361 to 153,383,000—an increase of only about 1.8 percent. The figures for both dates relate to the civilian population and exclude persons serving in the armed forces.

The relatively large increase in the population under 18 years old reflects the high birth rates of the 1950's. Moreover, the children born in the early 1930's, when birth rates were low, are attaining age 18 and leaving

this group. The number of persons under 18 is expected to increase at a rapid rate for several years as persons born during the 1950's replace those born during the depression years.

Adoptions have increased sharply in the last few years. In 1951 the number of adoption petitions filed in the United States probably reached 80,000—60 percent more than in 1944.

These estimates are based on reports from State public welfare agencies that transmitted adoption data to the Children's Bureau. In 1951, 33 States reported; and their reports provide the base for the estimate for that year.

There seems to be an increase both in the number of children adopted by stepparents or other relatives and the number adopted by nonrelated persons. In the small and perhaps unrepresentative group of 11 States for which such data are available a 65 percent increase took place between 1944 and 1951 in adoptions by relatives, and an 85 percent increase in adoptions by persons not related to the child.

Among the factors accounting for the increase in adoptions is the large number of homes broken during and following World War II by death, divorce, or desertion. In many cases the mothers remarried and the children were subsequently adopted by their stepfathers.

Columbia University Press publishes "Maternal Care and Mental Health," by John Bowlby, M.D. This information was accidentally omitted from the discussion of this subject that was published in the January issue of *The Child*.



UNDERSTANDING HEREDITY; an introduction to genetics. By Richard B. Goldschmidt. John Wiley & Sons, New York. 1952. 228 pp. \$3.75.

For those who have no knowledge of genetics to begin with, this book is probably not as good an introduction to the subject as several of the books that the author recommends to his readers. Nevertheless, those seeking highly authoritative information will find it in this book. For Goldschmidt is among those few great experimental researchers who, after generations before them had failed, have at last wrested from na-

ture the secrets of how heredity works.

The author is famous for his contributions to the genetics of sex, physiological genetics, and chromosomal theory. Yet the reader who did not know that fact in advance would hardly guess it from this book, which covers all the main principles of genetical science in a balanced fashion. Goldschmidt assures the reader that those main principles will not be changed by further developments in genetical theory. This assurance is noteworthy because it is given by a geneticist who has upset his colleagues' thinking as often—and as constructively—as anyone in the field.

Difficult terms are well defined as they come up in the text, and a convenient glossary is included. What the book lacks (from the layman's viewpoint) in the style of writing is largely compensated for by the liberal use of diagrams. Most of them are unusually well done, and they would be worth studying even if the reader did not attempt to assimilate all of the accompanying discussion.

The author uses few examples from human genetics, yet he stresses throughout the book that the principles derived from work with other animals apply equally to humans. Goldschmidt maintains that man cannot claim "any special position" or exemption so far as the laws of heredity are concerned. He points out that genetic differences are modified by environmental factors, but he does not say that behavior traits are more susceptible to environmental conditions than are physical traits. Indeed, he repeatedly mentions human psychological traits as being influenced by genetic factors in essentially the same ways as are other kinds of traits. Moreover, though man is unique in being able to hand down an immense treasure of knowledge, "no one receives any of it via hereditary transmission in the biological sense." The Soviet Politburo's denial of that fact is, he declares, a "partly ridiculous, partly mystical assemblage of nonsensical claims."

Bronson Price

CHILD PSYCHOTHERAPY. By S. R. Slavson. Columbia University Press, New York. 1952. 332 pp. \$4.50.

Although the author implicitly admits that he has already presented many of the ideas offered in this book, he nevertheless hopes that "new vigor and meaning is given them by a fresh restatement in a different context, in new relations, and in the integrative

approach to the biopsychosocial entity that is MAN."

The book indeed restates with "new vigor and meaning" the Freudian psychology, both orthodox and modified, for social workers and other nonmedical therapists. It has the "integrative approach" that, in a book by Slavson, makes the third and largest portion a novelty. Here the entire basis of psychotherapy is examined—its various aims, settings, and dynamics; the relationships between the child patient and his parents and between each of these persons and the therapist. Only one-fourth of the entire discussion is devoted to group psychotherapy as one of the many techniques within the broad scope of psychotherapy.

In the last chapter, a case history entitled, "Treatment of a Neurotic Nine-Year-Old Boy with Organic Deficiency," not only illustrates the application of the various techniques at the right time and place, but also demonstrates the operation of real team action among five workers—two psychiatric caseworkers, a group psychotherapist, a psychologist, and a psychiatrist.

Few social workers can afford to ignore this "restatement" of Slavson's, if they are concerned with the child and the "orderly and sound development of his dynamic drives for action, achievement, and reality control."

Hans A. Hiling

GUIDANCE IN A RURAL COMMUNITY; Green Sea—a South Carolina school district plans with and for boys and girls. By Amber Arthur Warburton. Alliance for Guidance of Rural Youth and the Department of Rural Education, of the National Education Association, 1201 Sixteenth Street, N.W. Washington 6, D. C. 1952. 156 pp. \$2.

More than 3 years ago the Green Sea High School District in Horry County, S. C., launched a guidance program, with the aid of the South Carolina State Department of Education and of the Alliance for Guidance of Rural Youth, to stimulate concerted community action to benefit rural children and young people.

Community problems concerning children, such as irregular school attendance and premature school leaving, were studied. These conditions, it was found, resulted from many causes, such as sickness, dissatisfaction with school, and use of child labor by parents at peak farming seasons.

In turn, recognition of each of these causes uncovered other condi-

tions needing correction. For instance, sickness was traced to unsanitary conditions at school and at home, inadequate food, and uncorrected physical defects. Removing these causes involved a broad community-betterment program. The program involved skillful counseling, improved methods of instruction, curriculum changes, and adjustment in school programs. Besides, guidance and counseling programs for parents were instituted to help them recognize conditions hindering the children and to develop and utilize resources available for helping the children mature.

The author conveys very well the wide scope of activities involved as well as the method of developing enthusiasm and carrying an excellent program forward in a strictly agricultural community. This book should serve as a guide for many rural areas that are in need of instituting a similar program. Such guidance activity, carried out on a large scale, would improve immeasurably the health, both physical and mental, of the people in our country.

O. Spurgeon English, M.D.

PARENT GROUPS AND SOCIAL AGENCIES; the activities of health and welfare agencies with groups of parents of handicapped children in Chicago. By Joseph H. Levy. University of Chicago Press, Chicago, 1951. 103 pp. \$2.

Two different types of groups are discussed in this report. These are: (1) associations of parents of handicapped children, which are composed entirely or predominantly of such parents — associations that are either affiliated with or operating independently of health or welfare agencies, and (2) projects sponsored by the agencies, in which groups of parents are brought together for education or counseling.

The author describes the composition and organization of various such groups in Chicago, their activities, and the relationships between the groups and the agencies. A chapter is devoted to the values and limitations of parents' groups. Another one raises some questions concerning the formation of such groups and the role of the social-work profession in relation to them; this chapter points out clearly the need for further study of these questions.

Ruth C. Olson

UNDERSTANDING YOUR CHILD.

By James L. Hymes, Jr. Prentice-Hall, New York. 1952. 188 pp. \$2.95.

James L. Hymes' name has come to be a synonym for guides for parents—pointed but reassuring, light-hearted but solidly meaningful. He knows child development, but what's more, he knows children. He knows how to communicate ideas, too.

Take for example his suggestions on bothersome behavior that arises out of the stage of growth a child is in:

"You tolerate it. You practice the fine art of looking the other way, of not hearing every word that is spoken, of letting a lot that goes on just slide off your back."

"You channel it, when you have taken as much as you comfortably can. 'You can't do this in here, but you can out there. . . . You can't do it now, but you can later. . . .'"

"You stop it, when you have racked

your brain and no bright ideas come; when despite all your thinking, you cannot stand it any more. You stop it firmly if you must, but you stop it gently, without anger and without upset. You stop it definitely if you must, but with no illusions that it is stopped forever."

Even when "you cannot stand it any more," and thoughtlessly use the last-resort method without meaning to, he says, there's always a chance to start over, always a chance to get a better grasp of reasons back of the behavior. Effective discipline, whether of the 2- or the 10-year-old, is "What frees. What opens up. What makes possible."

The helpful, deeply understanding advice offered in this small book will be sought over and over again. The amusing illustrations do a lot to point up the author's sensible and sensitive analysis of how parents—and teachers, too—can help to bring out in children the best that is in them.

Marion L. Faegre



Mar. 1-7. Save Your Vision Week. Twenty-seventh annual observance. Information from American Optometric Association, Jenkins Building, Pittsburgh 22, Pa.

Mar. 2. Child Study Association of America. Annual conference. New York, N. Y.

Mar. 15-20. National Council of Jewish Women. Twentieth triennial convention. Cleveland, Ohio.

Mar. 15-21. Camp Fire Girls Birthday Week. Forty-third anniversary. Information from Camp Fire Girls, Inc., 16 East Forty-eighth Street, New York 17, N. Y.

Mar. 18-20. National Society for the Prevention of Blindness. Forty-fifth annual conference. New York, N. Y.

Mar. 18-20. National Health Council. Thirty-third annual meeting. New York, N. Y.

Mar. 20-27. Jewish Youth Week. Fifth annual observance. Information from National Jewish Youth Conference, 145 East Thirty-second Street, New York 16, N. Y.

Mar. 24-Apr. 2. American Personnel and Guidance Association (formerly the Council of Guidance and Personnel Associations). (Four organizations—the American College Personnel Association, the National Association of Guidance

Supervisors and Counselor Trainers, the National Vocational Guidance Association, and the Student Personnel Association for Teacher Education—have become Divisions of the new American Personnel and Guidance Association.) Annual convention. Chicago, Ill.

Regional conferences, Child Welfare League of America:

Mar. 16-18. Central Region. Columbus, Ohio.

Apr. 16-18. Southern Region. Nashville, Tenn.

Apr. 26-28. South Pacific Region. Berkeley, Calif.

Apr. 30-May 2. North Pacific Region. Seattle, Wash.

May 18-19. New England Region. Swampscott, Mass.

June 10-12. Southwest Region. Denver, Colo.

Regional conferences, American Public Welfare Association:

Mar. 23-24. Southwest Region. Little Rock, Ark.

Apr. 26-28. Central Region. St. Paul, Minn.

May 6-8. Mountain Region. Bismarck, N. Dak.

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THE CHILD

APRIL 1953



INFANT MORTALITY AND PATTERNS OF LIVING

What directions should new research take?

ODIN W. ANDERSON

MORE AND MORE BABIES' lives have been saved in Western countries since the turn of the century. Before that 100 to 150 deaths under 1 year per thousand live births were common in countries like Sweden, England and Wales, Germany, and New Zealand; now an infant mortality rate over 50 is uncommon in such countries.

It is well known that infant mortality rates vary widely between countries, between areas within countries, and even between residential areas within cities. In 1949 Chile's rate was 169; Sweden's only 23. In 1947 Scotland reported an infant mortality rate of 27 in its most favored social class, but 89 in its most disadvantaged one. The difference suggests strongly the effect of environment on infant mortality. Again and again, in the extensive literature on infant mortality that has appeared in the last 50 years, we find that infant mortality differs in various groups of people, according to income, occupation, socio-economic group, country, color, and so on.

We know that a high infant mortality rate is associated with poverty; we know that the rate began to drop perceptibly in many countries at a certain stage of their technological development; we know that in the United States infant mortality before the turn of the century was higher in cities than in rural areas and that this continued until 1920 or so, after which the rates in cities were lower.

Infant mortality is often referred to as a sensitive index of health level. For example, Berlin in 1943 had an infant mortality rate of 66; 2 years

later, as a result of extreme disruption caused by bombing, the rate shot up to 359. A year later, in 1946, the rate dropped to 123, and in 1949 it was 75. Similarly, but to a lesser degree, France's rate increased—from 73 in 1941 to 109 in 1945. Additional evidence of the effects of war on infant mortality rates has been presented graphically by Collins. [1] Of course, high infant mortality rates in wartime are not caused only by bombing or other violence; many infant deaths are undoubtedly due to health hazards caused by wartime disruption of living patterns. Where the health level is low, whether in wartime or peacetime, the infant mortality is high accordingly.

Obviously, it is difficult if not impossible to isolate the specific factors influencing an infant mortality rate. A reasonable plan, however, is to look at fairly general factors and show how they are likely to operate at any given time and place.

Some biological factors, such as age and sex, are stable and are inde-

pendent of period and place; and another stable factor may be a constitutional predisposition to certain diseases. Individuals who may be predisposed to certain diseases because of constitutional factors can usually be found in a representative sample of the population. Such conditions can be regarded as biological facts that cannot be changed in the short run.

Other factors, basically biological, respond somewhat to environment; that is, their effects vary from time to time and from place to place. Death itself is a biological fact, but in some contemporary populations most deaths occur after age 65; in others most occur under 50. Similar differences are found even within the first year of life.

Another biological factor responsive to environment is birth, since the number of births in a population and the size of families vary considerably with circumstances. These in turn have real though undetermined influences on infant mortality. For example, a high birth rate is associated with a high infant mortality rate. A low birth rate could conceivably be associated with a high rate of deaths during the first month of life, because a low birth rate suggests a high proportion of first births, which in turn is associated with a relatively high mortality rate during the first month of life.

Among the socio-economic factors that influence the magnitude and distribution of biological factors are: Occupation; income; level of education; marital status; and place of residence, such as rural, urban, slum, high-income. These factors, which overlap considerably, indicate roughly socio-economic differences

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Under a fellowship granted by the World Health Organization, Dr. Anderson studied and observed in the field of preventive medicine in Great Britain, Norway, Denmark, and Sweden, in 1951. He is a member of the American Sociological Society and of the Society for Applied Anthropology, and a fellow of the American Public Health Association.

This article is condensed from a paper that Dr. Anderson gave before the Maternal and Child Health Section of the American Public Health Association at its eightieth annual meeting, held at Cleveland.

When Dr. Anderson gave the paper he was Associate Professor in Charge of the Social Aspects of Medicine, Faculty of Medicine, University of Western Ontario, London, Ontario, Canada. He is now Research Director of the Health Information Foundation, New York City.



New research may succeed in showing how mothering affects babies' health and survival.

among groups of people. They tell us little, however, of the quality of the human beings themselves unless we assume that the higher the socio-economic group the more biologically able to survive are the people. Except for so-called "problem families" and apparent social misfits, this assumption is scientifically untenable, because so many factors other than "ability," however defined, are responsible for the socio-economic niche a person or a family may occupy.

Socio-economic factors, of course, reflect patterns of living in the general population and in subgroups such as ethnic and occupational groups. Patterns of living, as we know, vary with religious beliefs and practices, attitudes toward human life, concepts of standards of living, hygienic habits—in short, what social anthropologists call culture.

Long-term trends show gains

Until the latter part of the nineteenth century, infant mortality rates in England and Wales, Scotland, and Iceland underwent great annual oscillations. At the beginning of the twentieth century, when the periodic epidemics of childhood communicable diseases were becoming less common and less virulent, these oscillations diminished. Many other factors have

operated indirectly to reduce infant mortality, but they are extremely difficult to isolate.

Sweden's records of infant mortality rates go back further than those of any other country. In the decade 1751-1800 the rates for different years ranged from 164 to 286 deaths in the first year of life per thousand live births. In the decade after that the range was from 141 to 232. Since 1812 the infant mortality rate has never exceeded 200, and in each of the following decades it has decreased consistently. In 1941-49 the rates ranged from 23 to 37.

In Scotland, for which we have reports as far back as 1855, the rates during the period 1855-1900 ranged from 108 to 138. In the decade 1901-20 the range was 92 to 129, and the rates decreased in each of the next two decades. For the period 1941-47 the range was 54-83.

Making allowance for the small population of Iceland (only 140,000 even today), we note that that country experienced extremely violent oscillations in infant mortality during the nineteenth century, but that during the twentieth century it has compared very favorably with any other area in the world.

The rates in other countries, such as Denmark and Norway, have had a similar pattern.

A similar change in trends of infant mortality rates has taken place in areas like India, Cyprus, Jamaica, and Spain; this suggests that the annual oscillations are narrowing and that the rates are becoming more stable, although declining.

At periods during which the infant mortality rates fell perceptibly in various countries the trends suggest that similar forces influencing the decline of infant mortality were operating simultaneously over wide areas. In the decade 1890-99 the rate fell noticeably in Denmark, England and Wales, Iceland, Scotland, New Zealand, Sweden, Switzerland, Norway, and France. In 1900-09, a similar fall took place in Luxemburg; in 1910-19, in Quebec and in India; in 1920-29, in Jamaica and in Spain; and in 1930-39, in Cyprus.

The decade 1890-1900 is an extremely important one in the history of infant mortality in Europe because so many countries experienced an improvement in such mortality. A similar improvement occurred in certain large cities in the United States, as reported by Winslow and Holland. [2] In other areas infant mortality rates improved distinctly in later decades, and it should be easy to demonstrate that the periods during which the rates began to decline are associated with sanitary and hygienic developments. This was true, for example, in Quebec, India, Spain, and Cyprus.

Some causes of death are being controlled

In saving the lives of babies less than a year old, the greatest gain has taken place during the period after the first month of life. Improvements in mortality during the first month of life have also been made, but hardly to the same degree as during the ensuing 11-month period. The reason for this lies in how well certain causes of death are being controlled. Prematurity and congenital malformations account for the largest proportion of deaths during the first

year of life, and usually the majority of these deaths occur before the end of the first month. The greatest proportion of deaths from respiratory and gastro-intestinal conditions usually occurs after the first month. These causes are responsive to environmental sanitation. Respiratory and gastro-intestinal causes have declined markedly in importance, and prematurity to a lesser degree; congenital malformations have not declined.

In a study of infant mortality in Cleveland, Green showed that from 1919 to 1937 the mortality among white infants 1 to 12 months of age improved 73 percent while mortality in the first month improved only 24 percent. [3]

Continuing studies of infant mortality in the United States made by the Children's Bureau reveal a similar pattern. From 1915 to 1949 the mortality among infants in the age group from 1 to 12 months improved 82 percent; and among those 1 month of age and under, it improved 52 percent. [4]

In Ontario, Canada, the rate of deaths during the first year of life improved 55 percent between the period 1921-25 and the period 1941-45, while the rate for the first month improved only 39 percent.

Association of low mortality rate in the first year of life with high percentage of deaths in the first month can be seen clearly when we compare deaths in some countries that have very high infant mortality rates with deaths in other countries that have very low rates. I have selected New Zealand, Sweden, and the United States as low-rate countries, and Guatemala, Mexico, and Egypt as high-rate ones. The period is 1945-47.

In New Zealand the death rate for the first year of life was only 26, and the percentage of babies that died during the first month was high—73. In Guatemala, whose rate for the first year was as high as 153, only 14 percent of the babies died in their first month. For all six countries a similar relation appears between the figures for the ages concerned, as will be seen in the following list:

Country	Deaths under 1 year, per 1,000 live births, 1945-47	Percentage of infants under 1 year that died in first month, 1945-47
New Zealand	26	73
Sweden	30	64
United States	34	71
Guatemala	110	36
Mexico	111	33
Egypt	153	14

Studies of the causes of infant mortality by age over a long period of time are few, but an excellent and authoritative one has recently been made by W. P. D. Logan, using data from England and Wales for the past 100 years.

The greatest relative improvements occurred in mortality from diseases that are more likely to occur after the first month of life—communicable diseases, and diarrhea and enteritis, rather than in mortality from prematurity, congenital conditions, and other prenatal and natal causes. Also, prenatal and natal causes accounted for about a third of the deaths in 1901-1910, and for nearly half in 1947. [5]

Obviously, socio-economic group, occupation, and income are closely related to one another, and in turn are associated with infant mortality rates. The higher the socio-economic group and income, the lower is the infant mortality rate for the group, although there are exceptions, which will be discussed later.

A study of infant mortality among the families of the rulers of European countries since the year 1500 by Peller reveals a noteworthy long-term trend among a wealthy segment of the population. [6] Over 8,460 children in these families were born to parents who married between 1500 and 1930. This relatively small number, statistically speaking, is subject to some error, but there is no doubt of the trend, as shown in the following list.

Time of parents' marriage	Deaths under 1 year, per 1,000 live births	Deaths under 1 month, per 1,000 live births
1500-99	193	98
1600-99	246	96
1700-99	153	60
1800-49	96	50
1850-99	41	17
1900-30	8	5

The improvements in mortality rates among ruling families—both for the first year of life and the first month—preceded the improvements among the general populations of the countries ruled by these families by 50 years or more. Infant mortality rates as low as 96 and 41 did not begin to appear in statistics for these countries until the end of the nineteenth century. An infant mortality rate of 8 has never been recorded for a general population, nor a neonatal mortality rate of 5. With present medical knowledge these low rates seem almost impossible to attain in a general population. But as reported for the ruling families they may be so low merely because they were calculated on such a small number of infants. The lowest recorded neonatal rate today for any country is Norway's 18; yet a rate of 17 was recorded for the ruling families as far back as 1850-99.

About a quarter of a century ago a crude but significant study of infant mortality in 1865 by age and economic group was made by Chapin. He separated the population of Providence, R. I., into persons who paid certain taxes and those who did not. He found that the infant mortality rate in the nontaxpaying group was twice that in the other group—190 and 93 respectively. [7]

In York, England, at the turn of the century, Rowntree made his famous study of poverty, a study that was repeated nearly four decades later. In this study the population was divided into four classes. One included only people who kept servants. The other three were groups of working people, and the groups were described, according to economic status, as "highest," "middle," and "poorest." As would be expected, he found the best infant mortality rate among the group that could afford to keep servants—94. In the three groups of working people the rates were: 247 for the "poorest," 184 for the middle group, and 173 for the highest-income group of workers. In 1936 the corresponding rates for the three groups were 78, 75, and 41. (The rate for the servant-keeping group in 1939 was not given.) [8]

At irregular intervals for the past 40 years the Registrar-General's Office for England and Wales has published infant mortality rates for each of five socio-economic groups. In 1939 the infant mortality rate for the lowest group was better than the 1911 rate for the highest. During the period from 1911 to 1930-32 the higher the group the greater was the relative improvement, but from 1930-32 to 1939 the four lower groups experienced gains greater than that of the highest, and their own improvements were almost equal. This may indicate that the upper group is reaching a "diminishing return." as its 1939 rate was relatively low—27. In both 1911 and 1939 the differences between the highest and the lowest groups in infant mortality rates are far greater than their differences in neonatal mortality rates, indicating that the neonatal mortality rates are relatively less variable among different groups and at different periods. Among all groups the infant mortality rate declined much more than did the neonatal rate.

As is to be expected, mortality rates by income alone follow the same pattern as do rates by socio-economic group.

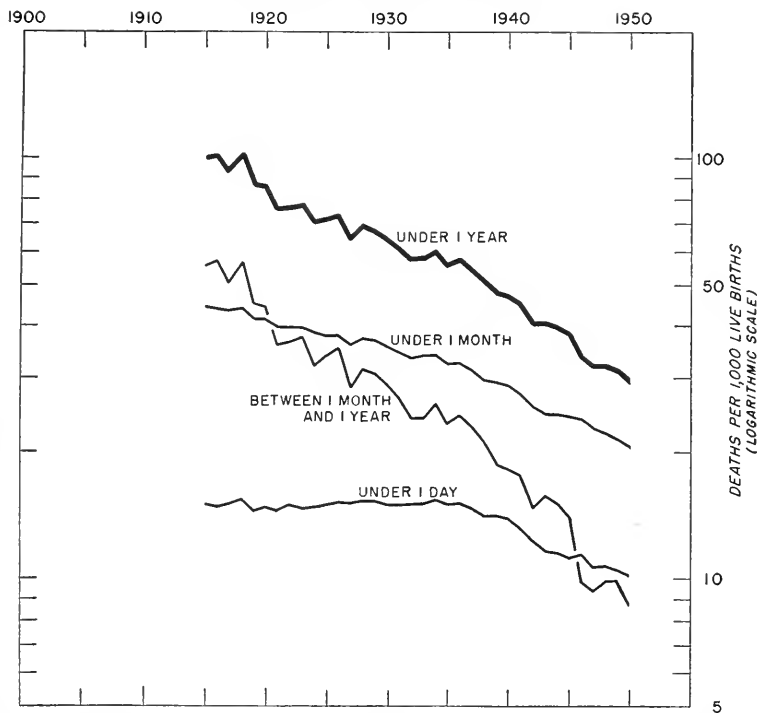
What a pioneer study showed

In an early study of infant and neonatal mortality, made by Woodbury for the Children's Bureau from 1911 to 1916, in eight cities in the United States, the earnings of the father were studied in relation to infant mortality in seven of the eight cities. In the highest-income group the mortality rate was 59.1; in the lowest the rate was 166.9. The neonatal mortality rate for the highest-income group was 38.2; for the lowest it was 55.8. As did other studies of income groups, this one showed much less variation in the mortality rates for the first month than for the first year. [9]

Green's aforementioned study of economic status and infant mortality in Cleveland, made in the periods 1919-23 and 1934-37, repeats the findings even when the differences between the income groups are slight. [10]

INFANT MORTALITY, 1915-49

(U.S. BIRTH REGISTRATION AREA)



Deaths between the ages of 1 month and 1 year have dropped rapidly, for these deaths are chiefly due to causes that can be controlled through improved community health conditions and better baby care. Deaths under 1 month of age, however, have decreased slowly; these babies die mainly from prenatal and natal causes, about which we know too little.

Our discussion of the relationships between income and infant mortality may well be closed by reference to a recently published study of 973 cities in the United States, 1939-1940, by Altenderfer and Crowther. In this study, again, the group of cities with the highest per capita income had the lowest infant mortality rate (28); the group with the lowest per capita income, the highest rate (73). [11]

Studies show us that infant mortality rates vary widely by residential areas within cities [12]; rural rates are higher than urban rates [13]; rates for nonwhites are higher than for whites [13]; certain ethnic groups have higher rates than others [14]; rates for foreign-born families are higher than those for native-born [14] and so on.

In summary, when we examine the gross relationships between infant

mortality and various socio-economic factors, we see that a low infant mortality rate goes with high income, with high socio-economic status, with well-paying occupations, and with other favorable socio-economic factors. An apparently obvious inference from this fact is that if all families could enjoy the general standard of living as to food, clothing, shelter, medical care, and public-health services that is attained by the level of society experiencing the lowest infant mortality rate, all families would then approximate this rate. In short, there is assumed to be a direct and undiminished correlation between a high standard of living and low infant mortality.

It might reasonably be suggested that where infant mortality rates go higher than about 30, an improvement in the standard of living will

have a long-run effect, as it has had since 1890 in various countries. It seems, however, that, for a given population, once the rate drops to about 30, the broad economic and social factors operate with lessening effect. Then an increasing influence on the rate begins to be exercised by personal factors in the care of the baby. Among these factors are (1) adequacy of mothering and (2) readiness—and ability—to use proved methods of infant care.

Perhaps the dividing line of 30 is too high or too low, but I submit that a theoretical line exists at one point or another. Perhaps that point is where the socio-economic level for the population as a whole is favorable, and family differences in this respect are small.

Tradition may be a factor

I suggest, then, that some fairly specific practices in infant care are relatively independent of economics, once basic essentials of living are accessible. (Given the essentials of living, use of a bottle sterilizer, for example, can have a greater effect in some families on saving babies' lives than an increase in income of \$500 a year.)

Attainment of an infant mortality rate of 15 to 20 would require excellent care of each baby. If this were given, a low rate could be achieved by families in Canada and the United States earning considerably less than families whose incomes are in the upper range of the income scale.

Among the 45 or more studies on infant mortality and social and cultural factors are two studies that suggest the plausible idea that, once the basic minimum standard of living has been attained in a given population, there is a point of diminishing return in the effect on infant mortality, of income, occupation, and socio-economic group.

When the Children's Bureau made its studies of infant mortality in eight cities, which I referred to previously, the infant mortality rate for the eight cities studied was 111, indicating a tremendous area of potential

improvement by means of broadside attacks on poverty, bad housing, and ignorance, with demonstrable effects in a short time.

One of the analyses was by color and nationality of mother, as follows: Colored; native-born white; foreign-born white (Italian, Jewish, French-Canadian, German, Polish, Portuguese). [15]

Even though the Jewish mothers were foreign-born, lived under as crowded conditions as the other foreign-born, had families as large as any other groups, and had an income that was much lower than that of the native-born white mothers, the Jewish group experienced the lowest infant mortality rate of all groups—54—and the lowest neonatal mortality rate—28. (The native-born white group had much poorer rates—an infant mortality rate of 94 and a neonatal rate of 42.)

Obviously factors other than general economic ones account for the low infant mortality rates among the foreign-born Jewish group. Closer examination would probably reveal a pattern of infant care of a high order embedded in the Jewish culture, since even bottle-fed Jewish infants experienced a lower mortality rate than infants of native-born whites. This is implicit in a Canadian study also. [16]

A second study that points to the influence of a factor in infant mortality other than economic ones was made in British Columbia, 1945-46. This gives infant mortality rates by occupation of father. The total infant mortality rate for the population studied was 31. The best rate among the occupation groups, 16, was attained, not by the professional and owner-manager groups, which had rates of 27 and 28, respectively, but by the clerical group, which hardly had a high income. To me this suggests especially good care of the babies in the families in the clerical group. [17]

I suggest that any further research to establish general relationships between infant mortality and such factors as income level and occupation is probably needless, because the

gross relationships have been established conclusively enough.

Toward the future

What research, then, other than purely medical, is needed concerning factors in infant survival?

One such field in which few studies have been made recently is illness of babies in relation to socio-economic factors. A study of this relation, made since World War II in a town in England, found the usual class difference in infant mortality, but suggested, at least tentatively, that no such difference was evident in infant sickness. [18] Evidence from a later study, based on a larger number of babies, who were drawn from all parts of Great Britain, disagrees with this. [19] This, of course, suggests need for further research.

Another subject, relatively untouched, concerns the effect of adverse socio-economic conditions on the unborn baby and on the ability of the mother to bear a full-term, healthy child. Such study is especially needed to help us understand the causes of deaths of infants just before birth, during birth, and in their first days of life. As a step toward preventing the numerous deaths—many associated with prematurity—during this critical period, we need a fuller understanding of the relation between these deaths and the adequacy of the care the mother receives during pregnancy. Such care, undoubtedly, depends to some extent on the socio-economic status of the family and the community.

Many other questions are still unanswered concerning socio-economic and ethnic factors in relation to babies' deaths: What are the environmental conditions in localities where infant mortality is still extra high by modern standards? How do traditional ways of caring for infants in various ethnic groups affect the survival of infants in these groups? These are only a few of the many questions that research workers might attack as steps toward making available to doctors and other health workers facts that will help them to save babies' lives.

(References are on page 134)



WHEN A COUPLE PLANS TO ADOPT A BABY

Group technique helps to clarify agency procedures

BEATRICE PRUSKI

COUPLES that apply to an adoption agency for a child often have very little idea of how the agency goes about getting children for adoption or of how it decides which applicants are to receive children. They are likely to feel that the process is mysterious and that the agency makes its decisions arbitrarily. When a couple does not receive a child for adoption they often resent this and feel that the agency must consider them in some way inferior.

Agencies use different methods of meeting this problem. One agency that uses a group technique in working with the applicants is the Los Angeles Adoption Institute, a non-profit, fee-supported agency. This agency serves not only couples who apply for a child, but the child's natural parents. And its first interest is the welfare of the child himself.

In the interest of the child, the

agency wishes to make clear to all applicants just what its purposes are, how it proceeds, and what it requires of couples wishing to adopt a child. It has found that an effective way to do this is by means of a group meeting, not as a substitute for separate, individual interviews, but as a preparation for them.

Couples face same problems

The group meeting gives the couples their first opportunity to talk with professional staff members of the agency. Before that, they have had only a brief conversation with a receptionist, who has checked their eligibility with regard to age, residence, citizenship, and length of marriage. The receptionist has noted also some additional information on race, religion, and number of children, has assured them of the agency's desire to be of service, and has explained that all general questions would be discussed at a meeting to be attended

by a number of other couples who also were applying for a child.

The meeting is held in the evening; usually about 10 couples attend. Joining with other applicants brings home to each couple that they are not alone with their problem. Also, group discussion can modify the extremely personal point of view of an individual family's situation. Each couple is part of a group in which all have faced the question of sterility and are now taking the same chances of disappointment in trying to adopt a child. They feel that all will be treated alike.

The group meeting helps to set the tone for all later individual relations with the agency workers. At the time of this first contact there are 20 clients to 1 professional worker. The

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At the time Mrs. Pruski wrote this article she was Director of the Los Angeles Adoption Institute.

couples have the support of a group of other couples who hope to become adoptive parents. Their problems are immediately identified to some extent with the problems of the agency, and they are asked to join in trying to solve them. Through questions that other couples ask, which might not have occurred to them, they see the whole situation in broader terms. Also, people who do not easily formulate in words the things that concern them, or who are shy about asking, benefit through the verbal facility of others. The dominance of the professional worker is reduced to a minimum; and a more mature, a more co-operative, and a more nearly equal relationship is established at the outset.

When the meeting begins

The method of handling the meeting varies somewhat with the worker who acts as leader. Since people begin arriving at least 20 minutes early, this time needs to be used in some way other than having them sit around self-consciously. At first, couples were asked to write down their ideas about their adoption plans, but later a more flexible plan was followed. The leader gives out paper and suggests that the people jot down questions they wish to ask, but she also carries on conversation with those who prefer to talk. The discussion starts not later than 10 minutes after the designated time.

Discussion may start directly with the questions uppermost in the minds of the couples, and gradually may be shaped into a general outline; or the leader may follow an outline, allowing time for discussion of each point. Whichever method is followed, a number of fundamental questions always emerge, although the content differs somewhat at different meetings.

All groups ask about the origin of the agency, who is behind it, and how it is financed. Since the Institute is fee-supported, the leader explains this type of financing, as well as the method of paying the fees. This leads up to the agency's procedure for applicants; this is discussed and then a



When a couple receives a baby from an authorized adoption agency, they can be sure that the child's interests have been given first importance in all the planning by the agency.

written statement of it is distributed for the group members to take home. Under this procedure, which aims to solve the problem of long lists of applicants and an indefinite waiting period, each couple's application moves according to definite time intervals, and the applicants always know where they stand.

Each group is asked whether they can think of a better plan. Although it is a long time since anyone has made a new suggestion, the discussion helps the applicants to realize that the agency is doing everything in its power to show them consideration.

Agency's procedure explained

Every group is interested in where we get our children, what we know about the child himself at the time of placement, and what we know about his background. The leader explains that the agency tells the adoptive parents all it knows about the child's background and makes clear that it would never place a child with a family that would be uneasy about any specific fact in his history. The role of heredity is discussed from the point of view of helping the applicants to clarify their own beliefs before the individual interview that

each couple will have with a staff member. Only two definite points are made: (1) That we have no conclusive evidence on what is hereditary; (2) that many characteristics run in families, but that this does not necessarily mean that any particular characteristic, other than physical ones, is transmitted by heredity rather than by environment.

The applicants always ask, and are frankly told, what the agency is looking for in homes for the children. It is most gratifying to see how simply and spontaneously this discussion focuses on the needs of the child, rather than on the needs of the applicants.

The leader begins with the question, "Suppose that you had to surrender a child of your own to be reared by strangers, what things would you want to be sure were present in that home and what things would you want to be sure were not there?"

All groups spontaneously place personality and emotional traits first. Experience has shown that it is best to keep this discussion in general terms. Too much detail in this field, particularly if illustrated by examples, tends to make some people

uneasy and self-conscious in the individual interviews that are to come. Properly handled, however, this discussion makes for greater ease and frankness later. The mere fact that the applicants gain some idea of what the agency is looking for, instead of depending on rumor about agency standards, gives them much more assurance.

The agency is able to make the point that it does not bar people because of any specific experience of their own, such as a broken home in their childhood, or a divorce. It is interested only in what these experiences have done to them; and the final result may be favorable, since people who have met and solved problems are stronger than those who have not.

The group knows the agency does not consider itself infallible in evaluating their situation and that it needs their help. The worker explains fully the agency's attitudes on finances, living space, health, and life expectancy, and it has never met with anything but complete approval of these. Each couple sees, as a result of discussion, that the agency's standards are not artificial values of its own.

Every adoption involves risks

It is well known that personal anxiety is often relieved through group discussion. People are able to ask questions that might be difficult for them in an individual interview.

For example, "If the child develops a handicap, will the agency take him back before the final adoption?" Couples usually ask this because they fear they might lose a child after they have become attached to him, but sometimes the question is whether they can return a child who is unsatisfactory to them, and what will be done about the fee in that case. They want to know what risks they take in regard to the child himself. The agency does not minimize these risks, especially since it believes in placing babies early in life.

Every group contains some people who are concerned about these risks, and some who dismiss the whole question on the ground that you take even greater risks with a child of your

own. In the discussion, the group performs its own therapy for extreme attitudes of either type. Many couples have told the worker later that they felt she was overstressing these risks, and so the agency now tells the groups how very few real problems it has encountered regarding the children placed.

Major anxieties seem to concern the question of the applicants' own qualifications and the reputed strictness and artificiality of agency practices in general. Here too the group sets its own standards and performs its own therapy. Sometimes, although rarely, this discussion arouses such anxiety that a couple decides not to proceed with the application. Most people, however, feel enough security in their marriage, and at this point have enough faith in the agency's fairness, to go ahead in a much more relaxed frame of mind after the group discussion.

Interesting emotional reactions are often noticed during the meeting. Couples often move physically closer together and frequently hold each other's hands. Naturally they feel an implied challenge in the discussion of qualifications; and in the face of it, surrounded by other people experiencing the same challenge, a couple will become more conscious of their unity and of how much they mean to each other. One can sense their decision to stand by each other. The expression of their faith in each other seems to help them go through the rest of the procedure with greater frankness and courage.

Couples have frequently told the workers, and also have mentioned to outsiders, how much more information they have given than they had originally intended to give. When they are asked why, they usually answer, "Because we felt from the beginning that you cared what happened to us and would do the best you could for us." The agency feels that the close emotional unity of the group meeting has a great deal to do with setting this tone.

One of the chief ways in which the group meeting saves time later is that it stimulates the applicants to visual-

ize themselves as possible parents before the individual interviews. Conscious effort is made to have them do this to prepare themselves to cooperate later in their interviews.

The agency is now trying to formulate the best content for group meetings in relation to the interviews. At the time of the individual interviews applicants are asked for comments on the group meeting. On specific points the comments are often constructively critical, and on the subject in general they are usually enthusiastic. People often tell the agency they have thought considerably about certain points afterward or have discussed them with friends.

Group meeting has several values

One value of the group meeting is the contribution it makes to the agency's own thinking and to clarification of policy. On a question that hinges on how people in general feel, an agency will gain more by bringing it up in a group meeting than by having the staff debate it among themselves. One such question is that of placement of a child with handicapped parents—whether or not such a child would be injured by community attitudes. This is a sensitive area today and one which no one can dismiss lightly in view of the number of men who returned handicapped from the war.

By the time the Institute set its policy on this, it had behind it the thinking and feeling of a number of the applicants, who certainly represent a broader sample of the community than does any agency staff. The couples talked very frankly on this point, with some differences of opinion but much fundamental agreement. It was evident that most of them felt that to preclude placement of a child in a home there must be some reason beyond the physical fact of a parent's handicap itself. They gave example after example of people they knew who were in this situation and of the neighborhood attitude and apparent effect on the children.

In group meetings, discussions of problems are kept general, but many

(Continued on page 134)



FOLLOW-UP OF 1950 WHITE HOUSE CONFERENCE ENTERS A NEW STAGE

National Committee hands torch to other groups

ELMA PHILLIPSON

AFTER 2 years of leading the work of advancing the findings of the 1950 White House Conference, the National Midcentury Committee for Children and Youth has placed the Conference follow-up in the hands of permanent groups and has voted to dissolve in the near future.

The Committee's two Advisory Councils, however, will continue to lead their constituent agencies in their follow-up work. (The Advisory Council on State and Local Action represents 51 State and Territorial committees and more than 1,100 local units. The Advisory Council on Participation of National Organizations represents 452 national organizations, whose membership extends into all the States and Territories.)

These decisions were announced at a Two-Year Anniversary Conference, held by the Committee and the two Councils, November 30 and December 1-2, 1952, at New York.

The meeting was held to inventory progress made throughout the country in translating into action the findings of the Midcentury Conference and to note what still must be done to reach the goal of the Conference—the goal of assuring for every

child a fair chance for healthy personality development.

Although five White House Conferences on children were held during the first half of this century, the 1950 Conference was the first to hold a follow-up meeting such as this one.

The Committee's chairman, Leonard W. Mayo, said frankly that the Midcentury Committee would have welcomed another year's active work—if money had been available. But, he said, the Committee was never intended to function more than 2 or 3 years.

"Two years of intensive follow-up under the National Midcentury Committee have already been provided," he said. "There are a good number of highly competent and experienced national organizations in the country that are not only capable of but interested in advancing the findings of the

White House Conference through their programs. This is an appropriate time to bring to a successful conclusion the work of the National Midcentury Committee."

What are the next steps?

Among the reasons why the committee should plan an early exit, Mr. Mayo said, are the solid job being done by most of the State and local committees and the necessity for leaving a clear field for the planners of the 1960 White House Conference.

Taking up the big question in the mind of every delegate, Mr. Mayo asked, "Where do we go from here?" As for future action, he asked the Conference to consider three questions:

1. How can we accelerate integration of the formal follow-up program of the White House Conference with the main stream of regular agency and community programs and services? Already, he said, the "main stream" has been modified in many parts of the country by the infiltration of the follow-up program and by many other constructive influences.
2. How can the impetus that has been given to the work of State and local committees be con-

ELMA PHILLIPSON, whose A.M. degree is from the University of Chicago's School of Social Service Administration, has been Executive Secretary of the National Midcentury Committee for Children and Youth ever since it was created, December 1950. For more than a year before that she had been on the staff of the White House Conference, working with the 464 national voluntary organizations that took part in preparing for the Conference. Previously she had had wide experience with such organizations.

Miss Phillipson is now planning and directing a recruitment project for the American Association of Medical Social Workers—a 6-month project made possible by means of a grant from the National Foundation for Infantile Paralysis.

tinued and strengthened? And in this strengthening how can encouragement be given to the process by which committees organized for White House Conference follow-up are moving into broader community planning for children and youth?

3. What provisions should be made with respect to the main phases of the follow-up program?

Foremost among the achievements of the 1950 Conference and its follow-up program are the impetus given to local, State and Territorial committees and the impetus generated by them, Mr. Mayo continued. These committees, he said, should strengthen and expand their activities. "Some committees have been broad planning bodies throughout their existence," he pointed out. "Others have already moved from programs devoted solely to preparation for and follow-up of the White House Conference to even broader planning and action functions, in cooperation with existing organizations."

Harking back to the National Mid-century Committee's original aims, Mr. Mayo specifically recommended:

1. Continued interpretation and publicizing of White House Conference findings by local and State committees, National organizations, and Government agencies.
2. Continued life for the Advisory Council on State and Local Action and the Advisory Council on Participation of National Organizations.
3. More emphasis on youth participation, which should become "a main interest of all youth-serving agencies."
4. Drafting of a research program in personality development and the broad field of child care, on the basis of the Fact-Finding Report of the White House Conference, by a qualified professional group.

Two additional questions, somewhat broader in scope, Mr. Mayo said, need to be asked because they bear such a close relation to the other problems.

The first question arises in view of

the fact that there is no general agreement on what constitutes a sound and comprehensive program for children and youth in a community. Shouldn't there be a definition, he asked, to serve as a goal for professional and lay workers in communities that are doing less than they might? It is likely that an answer will be found through a study being made jointly by the Children's Bureau and the Child Welfare League of America, he said.

Secondly, Mr. Mayo asked, should provision be made for the organization of a national group of outstanding citizens whose sole function would be to represent, and to act as a spearhead for, the broad interests of the children and youth of the Nation? This, he said, would be a group of distinguished citizens who would be responsible to the Nation and not primarily or exclusively to any organization.

Gains made in many States over the past 2 years in putting into practice the findings and recommendations of the Midcentury Conference were reviewed by Lyman Bryson, professor of education, Teachers College, Columbia University. Mr. Bryson drew his facts from the Committee's "Report on Children and Youth, 1950-52."

Mr. Bryson discussed some gains that the Committee had reported in different States. Among the gains: State aid was voted for more education for mentally retarded, hospitalized, and home-bound children; community health councils were organized; small towns were included in public recreation programs. And some disappointments were reported too, such as rejection by some adults of youth participation; no public-health nurse in many counties; juvenile offenders jailed with adults; defeat of legislation for a children's psychiatric-treatment center.

Speaking of the defeat concerning psychiatric treatment, Mr. Bryson said, "You can get help for a child whose difficulty is obvious and visible, but it is hard to persuade people to pay attention to children's emotional and psychological problems.

"It's extraordinarily difficult to equip, and to get the proper personnel for, good juvenile courts and for psychiatric treatment for juvenile offenders," he pointed out. "The public won't quite get over the combination of sentimentality and brutality which means that if a child is obviously handicapped something can be done about it, but if the handicap is secret, elusive, and difficult to get at, nothing can be done about it."

Going back to the bright side, Mr. Bryson pointed to the importance of small gains. "Don't think that because the great program is not immediately accepted, the little victory doesn't count," he said. "The little victories give the campaigners something to talk about; they encourage the staff and the committee members, and they give the local citizens something to be proud of."

Young people's opinions valued

A great need today, Mr. Bryson said, is to get people to look at hurt souls. "But it's going to be hard to minister to the souls of the young unless we know what youth is thinking and doing.

"We had young people in the meetings at Washington in 1950. They were disruptive, they were sometimes extravagant, they were often wise; they were always interesting; and they were eminently worth while.

"I've tried a number of quite extensive experiments, trying to get at the contributions which young people make to public opinion. I've found that they nearly always have good opinions. Just on a straight Yes or No vote I would be as willing to put any nontechnical public question to the vote of the young people—say between 16 and 20—as to any other group in the United States.

"The reason why they don't contribute much to the deliberations and operation of public agencies is that they very often don't know why they have those good opinions.

"There are two fallacies in this field. One is the fallacy of young people who think that intelligence is a substitute for experience. The other is that of older people who think that

experience is a substitute for intelligence.

"The real reason why we want youth in our deliberations is not for their contribution, but for what it does for them. Young people are living now. Citizenship is not only something you learn for the future, but it's something you practice for what it does to you while you're practicing it. Young people have a right to that, for its own sake and for now."

Concluding, Mr. Bryson cautioned against resting on the progress made so far. "Each of us," he said, "must help constantly to make a different social atmosphere in America, help constantly to make more people sensitive to the things that are wrong, to straighten out conditions which are evil and damaging."

Melvin A. Glasser, who was executive director of the Midcentury White House Conference, pointed out that young people have been getting more plentiful than ever. There were 35,000,000 children under the age of 18 when President Theodore Roosevelt called the first White House Conference in 1909. In the next 40 years that figure was increased by only 12,000,000, but in the current decade alone an increase of 10,000,000 is expected.

Midcentury marks improvements

Significant gains cited by Mr. Glasser were: New emphasis on children's emotional needs, increased activity of citizens, greater attention to the teen-age group, more cooperation among the professions, and heightened interest in fact finding and research. He cautioned against being content with the status quo and urged the delegates to keep pushing forward.

Martha M. Eliot, M.D., Chief of the Children's Bureau, spoke as vice chairman of the Federal Interdepartmental Committee on Children and Youth.

"The meetings of this anniversary conference," she said, "have made me realize more keenly than ever before the effective leadership which the National Midcentury Committee has

given to the White House Conference follow-up program."

Dr. Eliot explained the work of the Federal Interdepartmental Committee on Children and Youth, which represents 35 Government agencies, and showed how both public and private agencies gain from a friendly interrelationship.

"Each older generation piously hopes that its successors will be able to avoid the mistakes of its forerunners and triumph over the legacy of difficulty bequeathed to it," said Dr. Buell Gallagher, President of the College of the City of New York. "Yet each oncoming generation is forced to

PUBLICATIONS of the Midcentury White House Conference, including the "Report on Children and Youth, 1950-1952" (46 pp. \$1) and the "Directory of State and Territorial Committees Cooperating with the National Midcentury Committee for Children and Youth" (60 pp. 75 cents), should be ordered from Health Publications Institute, 216 North Dawson Street, Raleigh, N. C. Ask for quantity and packet rates.

Health Publications Institute, a nonprofit organization, has on sale all the Midcentury Conference publications except "Personality in the Making," which is published by Harper & Bros. (454 pp.).

grow up in a world where adults set the patterns of control and determine the possibilities for growth. Each generation's teeth are set on edge by the sour grapes eaten by its fathers.

"No matter how much progress can be shown over the last half-century, we know that the next half-century still poses for the present generation of adults the same old problem—how to release the leadership of today's children in constructive directions without corrupting it with the prejudices, foibles, and chicanery of today's adults."

Dr. Gallagher pointed out that it won't be easy to give children a better chance. Citizens can be rallied to battle against "entrenched evil when it is clearly unmasked," but they are slow to meet the need for patient, plodding work on constructive projects. Too many are willing to stop at the talking, or listening, stage.

And even when they move ahead, much of their energy is wasted in the cumbersome process of building the kind of machinery that will ultimately get results.

"Since today's children will be tomorrow's leaders, the only way to make sure they will lead well is to give them good leadership today," Dr. Gallagher said.

"We must work very hard on today's adults," he continued. "There is no other way to make sure that those who today lead tomorrow's leaders will not corrupt and ruin the bright hope on which mankind must rely."

As a goal in reforming the current crop of adults, Dr. Gallagher suggested that adulthood should "seek earnestly to recapture the virtues (without the vices) of youth, to become childlike without being childish."

Margaret Price, chairman of the Advisory Council on State and Local Action, said: "In some cases I believe the citizens are ahead of us in their desire for action." She cautioned the State committees to make sure in future planning "that this citizen interest shall neither die nor be siphoned off into unproductive channels." Mrs. Price announced that the Advisory Council on State and Local Action is planning to expand its activities, and that another meeting of the Council is to be held toward the end of 1953.

George Corwin, vice chairman of the Advisory Council on Participation of National Organizations, said that the 92 national organizations represented at the meeting had agreed to urge all national groups to step up their efforts to eliminate prejudice and discrimination; to strengthen local welfare councils, to develop more lay leadership, to work for vital legislation, and to encourage youth participation.

A strong plea for more attention to young people who will not go to college or may not even finish high school was made by Charlotte Peterson of Detroit, a Wayne University student who is vice chairman of the Michigan Youth Advisory Council.

"The schools' educational and counseling programs are not as effective

as they could be," she said. "Too often they pay attention to the top group who will go to college, or to the troublemakers at the bottom."

Better vocational-counseling service, coupled with full recognition of the dignity of all forms of labor, are two main goals of the Michigan Youth Advisory Council, Miss Peterson reported. Another aim is to give boys and girls "the opportunity to acquire an actual, constructive work experience on a job they are best qualified to perform." Employers and labor unions should help work out a feasible apprenticeship program, she said.

Strengthening of State and Territorial youth committees to make them better watchdogs was recommended by the Advisory Council on State and Local Action.

The delegates urged that every State committee have a formally defined purpose and a clearly outlined structure.

Committee members, rather than the executive secretary, should be primarily responsible for raising money, the group agreed. Because the planning functions of the committees involve both public and private services, it was recommended that funds be sought from public and/or private sources.

The importance of regularly scheduled conferences and regularly published newsletters was emphasized. It was suggested that State and Territorial committees give special attention to one or more projects with youth participation and to enactment of needed legislation.

How to eliminate prejudice and discrimination that still persist in the programs and staff and membership policies of many national organizations was discussed by the Advisory Council on Participation of National Organizations at a work session.

Many national organizations, the delegates reported, have changed their bylaws or adopted policies to prevent discrimination in their own ranks, and to avoid holding conventions in cities that practice segregation.

"We recommend," the discussion group announced, "that national or-

ganizations gather the facts about the makeup of their personnel and their constituency and their existing practices and then face the implications of these findings in terms of policy changes.

"We recommend that national organizations help set a pattern by operating with completely integrated national clerical and professional staffs."

Fairness called for

The delegates pointed out that discrimination is not limited to racial and religious groups but extends also to physically handicapped persons and low-income families. Action to stop discrimination in these areas is also needed, it was agreed.

The Committee's new pamphlet, "Report on Children and Youth, 1950-1952," was distributed at the Two-Year Anniversary Conference.

Based on material supplied by State and Territorial youth committees, by national organizations, and by Federal agencies, the report is packed with examples of voluntary and official action in carrying out the findings of the White House Conference.

The Committee has issued another new publication, the "Directory of State and Territorial Committees Co-operating with the National Mid-century Committee for Children and

Youth." This is far more than just a directory. It includes highlights of the present activities of many of the State and Territorial Committees' programs, as well as some of their plans for the future. As the Mid-century Committee chairman says in the foreword, "It reveals amazing and admirable ingenuity, skill, and leadership on the part of State and Territorial Committees in providing increasingly better opportunities for the healthy personality development of all our children and youth."

As was reported in the February issue of *The Child*, the National Mid-century Committee has closed its office in New York. The Committee will not disband, however, until July or possibly later in 1953. General correspondence should be addressed henceforth to the chairman, Leonard W. Mayo, director of the Association for the Aid of Crippled Children, 580 Fifth Avenue, New York 36.

The Advisory Council on State and Local Action should be addressed in care of the secretary, Douglas H. MacNeil, 222 West State Street, Trenton 8, N. J.

The Advisory Council on Participation of National Organizations should be addressed in care of the chairman, Robert E. Bondy, National Social Welfare Assembly, 1790 Broadway, New York 19.



At the Midcentury Conference, in 1950, at which young delegates took part in discussions, adults found that the young people had good opinions, though they didn't always know why.

INFANT MORTALITY

(Continued from page 126)

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Copies of the complete paper now available from the Children's Bureau.

ADOPTION

(Continued from page 129)

couples remain to ask questions later about their personal situation. This also saves much time for everyone concerned, since special problems can be clarified before the couple makes another special trip for an interview. Through the discussion they become aware of problems that might otherwise not emerge until later in a personal interview.

As already noted, preparation for rejection of applications is achieved in the group meeting as it never could be through any number of individual interviews. The applicants know that only a few of the couples who are sitting there with them can possibly be given a child, because there are not enough children to go around. They know that all these people are sensitive about sterility, and that this condition is one of the main reasons why they are at the meeting.

The agency explains that the applicants will be notified of rejection simply by a form letter and tells why no reasons will be given at the time. The couples know that they will be told during the interview about tangible reasons such as finances or health or about anything they could change without getting involved in problems of psychotherapy.

When the couples are first asked if they would like to have reasons given, the answer is almost universally yes. However, the leader points out what it might do to a marriage if the reasons for rejection were focused solely on one person and not the other. Again, she shows that attempting such explanations would add to the size of the fee. She makes clear that if the explanations were given briefly and not followed up by help in solving the problems, the result would be at least nonconstructive and might be injurious. When the applicants stop to think of all these factors most of them come to agree with the agency practice. People with any degree of imagination or insight realize that in applying for a child they are not asking for discussion of deep emotional problems to which they may have al-

ready worked out some sort of adjustment, or which may not even exist.

The agency stresses that when it has nothing constructive to offer it has no desire to convince the couples that its decision is right, and there is always the possibility that its workers are mistaken. Although the agency must abide by its own best judgment in doing its job, no one is infallible in evaluating emotional traits and estimating their effect upon a child who is not yet there. It would be unfortunate if anxieties were aroused that might not even be based upon reality and that the agency is not prepared to work out with the applicants.

Not enough babies for all

There is no doubt that not giving reasons for a rejection can arouse great anxiety. However, it is made clear that because of the surplus of applicants, standards for acceptance are high, and therefore reasons for rejection are not necessarily serious.

It is true that, in spite of this preparation, some applicants do request reasons at the time of rejection, but the number is very small and the request is usually prefixed by the statement, "We know that this is contrary to your policy, but we hoped in this case . . ." Usually a restatement of the agency's position is sufficient to close the matter without great resentment, although the agency sees its share of people whose only desire is to strike out irrationally at something. However, for most reasonably well-adjusted people, and these make up the vast majority of couples who apply for babies to adopt, a good preparation for the rejection is found in the group meeting.

The group technique has proved so successful that the agency's director is now considering extending it in two other possible ways. One would be to have small groups of accepted applicants come together prior to receiving their child for a discussion of child care. The other would be for small groups of couples ready for final adoption to discuss the court procedure and questions of later child development.

Reprints in about 6 weeks

IN THE NEWS

Jobs in social work. A public employment service office, manned by employment specialists and serving as a Nation-wide clearinghouse for jobs in the social-work field, will be a feature of the 1953 National Conference of Social Work in Cleveland.

The job clearinghouse will be installed on an experimental basis by the United States Employment Service in cooperation with affiliated State Employment Services. The specific purpose of the plan is to provide arrangements for bringing job orders and job applicants in the social-work field together. A centrally placed booth, staffed by experienced employment service interviewers, will be available to bring together interested applicants and agency representatives who have listed vacancies.

Advanced training courses for child-care specialists of many countries will be conducted in 1953 by the International Children's Center in Paris, an institution aided by the United Nations International Children's Emergency Fund.

The four courses offered deal with: (1) The prevention of tuberculosis in children, including methods of BCG vaccination; (2) the rehabilitation of motor-handicapped children; (3) social pediatrics; and (4) problems encountered in prenatal care and at the time of childbirth.

Fellowships for doctors, health officers, and social workers are offered to help personnel in some 50 countries and territories to participate in the training, which will include field trips to a number of French institutions.

In addition to offering the training courses, the Center will continue a number of research projects on child-development problems, will serve as a documentation center in the field, will issue publications on child-care questions, and will organize a popular educational exhibition.

Young people of working age. Because fewer babies were born during the depression of the 1930's, the number of boys and girls now reaching working age—15 years—is comparatively small. There was a drop of 13 percent in the 15- to 19-year age group in 1950 as compared with 1940 (from 12,333,523 to some 10,732,000), according to decennial-census figures. This is the age group now leaving school and college and starting work. Military demands on the boys and early marriage and

childbearing among the girls further reduce the number of new workers.

By 1960, however, because of the large number of births during and since World War II, the Bureau of the Census estimates that the number of young people in the 15- to 19-year age group will be 30 percent greater than it was in 1950.

Millions of mothers employed. Just over 5¼ million women workers were mothers of children under 18 in April 1951, according to the Bureau of the Census; about 2 million had children under 6.

Absence of the husband tends to force mothers into seeking employment. Of all mothers with children under 18, one-fifth of those with the husband present and one-half of all other women that were ever married were employed.

Even among mothers whose children were all under 6, the proportion of working mothers was considerable—14 percent for those with husband present, and 37 percent for all others ever married.

To Our Readers—

We welcome comments and suggestions about **The Child.**

CALENDAR

Apr. 6-10. Association for Childhood Education International. Annual study conference. Denver, Colo.

Apr. 7. World Health Day.

Apr. 8-10. United States-Mexico Border Public Health Association. Eleventh annual meeting. El Paso, Tex., and Ciudad Juarez, Chihuahua, Mexico.

Apr. 8-11. International Council for Exceptional Children. Thirty-first annual convention. Boston, Mass.

Apr. 8-12. American Heart Association. Twenty-ninth annual meeting and twenty-sixth scientific sessions. Atlantic City, N. J.

Apr. 10-11. American Academy of Political and Social Science. Fifty-seventh annual meeting. Philadelphia, Pa.

Apr. 13-15. Girls Clubs of America. Eighth annual conference. New York, N. Y.

Apr. 13-19. National Boys' Club Week. Information from Boys' Clubs of America, 381 Fourth Avenue, New York 16, N. Y.

Apr. 18-19. American Psychosomatic Society. Tenth annual meeting. Atlantic City, N. J.

Apr. 19-25. National YWCA Week. Sixth annual observance. Information from National Board, Young Women's Christian Association, 600 Lexington Avenue, New York 22, N. Y.

Apr. 20-22. Sixteenth Annual Groves Conference on Marriage and the Family. Sponsored by the University of North Carolina. Held at Ohio State University, Columbus.

Apr. 20-23. National Council of Juvenile Court Judges. Sixteenth annual conference. The National Juvenile Court Foundation will meet concurrently with the National Council. New Orleans, La.

Apr. 21-26. International Union Against the Venereal Diseases. Nineteenth general assembly. Rotterdam, Netherlands.

Apr. 22. National Social Hygiene Day. Information from the American Social Hygiene Association, 1790 Broadway, New York 19, N. Y.

Apr. 25-May 2. Boys and Girls Week. Thirty-third annual observance. Information may be obtained from the nearest Rotary Club.

Apr. 27-28. American Association for Cleft Palate Rehabilitation. Eleventh annual convention. Atlanta, Ga.

Apr. 30-May 3. American Psychoanalytic Association. Annual meeting. Los Angeles, Calif.

Regional conferences. American Public Health Association:

Apr. 23-25. Southern Branch. Atlanta, Ga.

June 10-13. Western Branch. Los Angeles, Calif.

Regional conferences. Child Welfare League of America:

Apr. 16-18. Southern Region. Nashville, Tenn.

Apr. 26-28. South Pacific Region. Berkeley, Calif.

Apr. 30-May 2. North Pacific Region. Seattle, Wash.

May 18-19. New England Region. Swampscott, Mass.

June 10-12. Southwest Region. Denver, Colo.

Illustrations:

Cover, Esther Bubley.

P. 127, Jane Schroeter.

P. 128, courtesy of *Parade* and the Spence-Chapin Adoption Service.

P. 130: Left, seal of the Midcentury Conference, drawn by William N. Thompson; right, Esther Bubley for UAW-CIO.

P. 133, Singer for Children's Bureau.



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SOCIAL SECURITY ADMINISTRATION
Arthur J. Altmeyer, Commissioner

CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

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THE CHILD

MAY 1953



CHILD HEALTH DAY, 1953

by the President of the United States of America

a Proclamation

WHEREAS the Congress, by a joint resolution of May 18, 1928 (45 Stat. 617), authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day; and

WHEREAS the health and wholesome development of our children are matters of the deepest concern to all Americans; and

WHEREAS the stresses and strains of our times create many problems bearing on the spiritual and emotional health of our children and are reflected notably in juvenile delinquency; and

WHEREAS we have made tremendous advances in overcoming the most severe physical hazards of childhood, and are now striving to make equally significant progress in understanding the nature of emotional health, in order that our children may grow into mature, responsible citizens of a democracy:

NOW, THEREFORE, I, DWIGHT D. EISENHOWER, President of the United States of America, do hereby designate the first day of May, 1953, as Child Health Day; and I urge all parents and young people, and all other individuals, as well as agencies and organizations interested in the well-being of children, to increase their understanding of the emotional, social, and spiritual growth of children, so as to apply this understanding in their day-to-day relations with the rising generation.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this twentieth day of February in the year of our Lord nineteen hundred and fifty-three, and of the Independence of the United States of America the one hundred and seventy-seventh.



By the President:

Dwight D. Eisenhower

Walter P. Reuther

Secretary of State

TO UNDERSTAND CHILDREN BETTER



OVETA CULP HOBBY

Americans could do a tremendous job of preventing crime, unhappiness, and mental illness if they would carry out the objective of Child Health Day for 1953.

Child Health Day, proclaimed by President Eisenhower for May 1, 1953, is the day on which all Americans are urged "to increase their understanding of the emotional, social, and spiritual growth of children, so as to apply this understanding in their day-to-day relations with the rising generation."

We know that children who do not get the chance to develop their fullest capacities in each stage of their growth run larger risks of growing into maladjusted, unhappy, and not fully productive adults.

All along the way we see evidence that the knowledge we have about child growth is not being fully applied. We see it in rising juvenile-delinquency rates, in a fantastically large national crime bill, in mounting numbers of emotionally disturbed, mentally ill people.

There is nothing that leads us to believe that people are born delinquents or criminals. It is in their childhood that tendencies in these directions first appear.

If, as parents, we can understand more about the growth processes of childhood, we increase the chances that our children can develop the emotional and mental strength required to live happy, useful, and satisfying lives.

Those who are interested in learning more about the stages of growth might start with "A Healthy Personality for Your Child," a booklet published by the Children's Bureau. It sums up in popular form what we know today of how children grow emotionally and has a companion "Discussion Aid" for groups that want to talk over the problems they encounter in rearing and working with children.

The Children's Bureau is proud to join with the State and local health departments, traditional sponsors of Child Health Day activities, in their observance of May Day.

The 1953 observance marks the twenty-fifth year that Child Health Day has been observed by Presidential proclamation. It was authorized

by a joint congressional resolution, passed in 1928, which called attention to "the fundamental necessity of a year-round program for the protection and development of the Nation's children."

In the quarter century since President Coolidge issued the first Child Health Day Proclamation, through new medical and scientific discoveries and extensive public-health work, our country has made tremendous advances in overcoming many of the great physical hazards that used to threaten children.

In the words of President Eisenhower, "We are now striving to make equally significant progress in understanding the nature of emotional health in order that our children may grow into mature, responsible citizens of a democracy."

OVETA CULP HOBBY became the first Secretary of Health, Education, and Welfare April 11, 1953.

On that day, the President's Reorganization Plan No. 1, 1953, went into effect, changing the former Federal Security Agency, of which Mrs. Hobby was Administrator, into the U. S. Department of Health, Education, and Welfare.

Mrs. Hobby was born in Killeen, Tex. She received her education in the public schools of Killeen, under private tutors, and at Mary Hardin-Baylor College.

In 1942 when the Women's Army Auxiliary Corps was created Mrs. Hobby was appointed as Director. In 1943 the Corps became the Women's Army Corps, and Mrs. Hobby served as its Director, with the rank of Colonel, till 1945. She was awarded the Distinguished Service Medal by the United States Government and the Military Merit Medal by the Philippine Government.

At the time of her appointment as Federal Security Administrator, Mrs. Hobby was editor and publisher of the Houston *Post* and

executive director of Station KPRC-AM-FM-TV.

Mrs. Hobby served as consultant on the Bipartisan Commission on Organization of the Executive Branch of the Government, and later on the Board of Directors of the Citizens Committee for the Hoover Report. She was on the National Advisory Council of the American Cancer Society.

She is a former member of the Board of Governors of the American National Red Cross and has been a member of the Defense Advisory Committee on Women in the Services. For several years she served on the Board of Directors of the National Conference of Christians and Jews.

Mrs. Hobby holds honorary degrees from Baylor University, Mary Hardin-Baylor College, the University of Chattanooga, Sam Houston State Teachers College, Colorado Woman's College, and Bard College. In 1950 she was awarded honor medals for distinguished service to journalism by the University of Missouri and by the Texas Press Association. In 1951 her name was added to the roster of the South's Hall of Fame for the Living.

FOR BETTER AND HAPPIER CHILDREN

School Is More Than Three R's

EARL J. McGRATH

*Commissioner of Education,
Department of Health, Education, and Welfare*

Most children like to go to school. They like to go for a variety of reasons. Usually, when boys and girls are enthusiastic about school it is because they feel the teacher likes and understands them. In return, they like her.

All over the country, there are classrooms that reflect good pupil relationships. In such classrooms, every child comes to know that:

—he has friends in the class, his being “there” makes a difference, and he is missed when he is away.

—the teacher and principal believe in him. He and his schoolmates have a part in planning what goes on in school. Their ideas count.

—his work is important to the group. Once he accepts responsibility for something which he is able to do and which is needed by the group, he must carry through; he approaches his responsibility with confidence that he can carry it. He knows that he does not have to work exactly as others do; instead, he can work at a pace and in a way that is comfortable for him. He learns, however, that he must often work hard to do the work he really wants to do.

—he can get help in carrying out his responsibilities from his teacher and classmates, from books and other source materials as he works alone, in a group, or as a committee member.

—he is becoming more skillful day by day as he learns to read, write, figure, listen, and talk; to make decisions on the basis of what he reads, hears, sees, and discusses; to express himself creatively through different mediums; and to work with materials and tools. He knows that as he becomes more skillful both he and the group profit.

—other children respect his rights

and belongings and he is learning to respect their rights and belongings.

—he can trust the teacher and his classmates and they can have faith in him.

—the teacher is a friend who will listen to him when he is troubled and will hold in confidence the things he tells her in confidence.

—he and his teacher and his parents are all friends, working together to help him “grow up” and since he is doing his best they, as well as he, are satisfied with his progress. Consequently, he is free from anxiety, tension, and fear.

Prescription for Peace

BROCK CHISHOLM

Director General, World Health Organization

The observance of Child Health Day in the United States is a reminder to all of us of the very intimate relationship which exists between the health of the child—when defined as total health—and the solution of the great crisis which confronts humanity today.

If in our ignorance, our short-sightedness, our lack of courage and vision, we continue to deny our children the blessings of physical well-being; if, moreover, we continue to inculcate in them prejudices, uncritical and emotional beliefs in unreasonable things, excessive fears of others and, as a result, aggressive desire for power and domination, then we can be sure that the world of tomorrow will be a world of fear, of chaos, of cruelty—and of death.

If, on the other hand, we succeed not only in making our children physically healthy, but also in freeing them of our taboos, our anxieties, our destructive impulses; if we teach them to feel, and to act in accord with, a sense of responsibility for the welfare of their fellow human beings—not just locally, not just nationally, but for the whole human race, then we need not worry about our future

and theirs; it cannot but be secure, peaceful, and truly rich in the values that make life worthwhile.

To resolve on May 1 to dedicate our energies to the healthy emotional development of our children will be to provide ourselves and them with one of the strongest possible guarantees that man's age-old dream of a better and happier world shall after all become a living reality.

Clue to Child Health

R. H. FELIX, M.D.

*Director, National Institute of Mental Health,
Public Health Service,
Department of Health, Education, and Welfare*

On Child Health Day in 1953, we can see the gradual evolution during the past few years of a new concept in child health.

We recognize that the child with persistent behavior problems is neither happy nor healthy, and that a crippled personality may be just as serious a handicap as a crippled body. We also recognize that it is impossible to deal with the child alone, and that we must also deal with the adults upon whom he is dependent.

It is gratifying that communities are making efforts to help both children and parents by establishing more child-guidance clinics. All child-guidance workers recognize how important it is for parents to see that a child feels wanted and loved throughout childhood.

Parents should help the child develop his own personality, and not try to make him a carbon copy of someone else. He should not be over-protected or overindulged, but should rather be able to feel that he can rely on his parents for consistent attitudes, sympathetic understanding, and a gradual “loosening of the apron strings.”

Child Health Day should remind us all of our obligation to help every child grow up to be a well-adjusted individual, able to face his duties with resourcefulness and to choose his opportunities with wisdom.

CHILDREN IN THE CONTEMPORARY SCENE

GEORGE E. GARDNER, Ph.D., M.D.

ONE of the hardest things in the world for man to evaluate is his present world—his contemporary scene—whether he views it solely in relation to his own position, enmeshed in his own series of relationships, or whether he tries to estimate the worth of his entire society in respect to some particular social issue or social program. It is much easier for him to appraise a historical segment of the past or to speculate upon the fruitfulness of a future plan than to state categorically and emphatically just where he now stands. His own involvement or investment in his numberless roles in the present precludes accuracy and minimizes objectivity.

But he is forever trying such measurements, and I too shall try as a physician and psychiatrist to outline for you what the American child and parent face as they seek what seems to me to be that ultimate goal for both—namely, a comprehensive child-care program in a democratic society. I have no doubts whatsoever as to the correctness of the goal, and I would be particularly emphatic in my inclusion of the word “comprehensive” and the word “democratic.” For you will note as I proceed that among the shortcomings that we have in the care of children in our country today can be ascribed either to a lack of “comprehensiveness” or to a lack of “democraticity” or to both.

This then is the larger measurement that I would apply—or better, it is the microscopic low-power view that one can take of our present scene. But the high-power view, and the most revealing measure applicable, is that which involves not the whole field, but the selection merely of the individual child within an area — any specifically designated child in any area of our field. Only



The child-guidance clinic, with its emphasis on psychiatric care, is less than 50 years old.

through such samplings can one get an estimate of how far we have actually approached our goal of democratic comprehensive child care, and only in such samplings do we discover the moderate—or the painful—lacks that must be eradicated. My basic thesis, therefore, is that our present scene—or any society—can be judged in respect to the adequacy of its child care only by estimating what programs have been devised in that society to care for the *individual needs* of the individual child, and to what extent this program of individuation has become universally applied. The battles that have been waged and won to secure the more

adequate care of children, whether in the area of sheer protection of life, the prevention of disease, universal education (or specialized education within this framework), the treatment of the delinquent child or the emotionally disturbed child—all these battles have been waged for the expansion of the concept of individual treatment in accordance with individual needs.

Advantages not universal

Then how does our contemporary scene measure up? I am intrinsically an optimist. In other writings I have declared my position as an optimist as regards both American children and American parents, and I am happy to do so again and with it add my optimism regarding the present-day scene in general. I do this in the hope that it may have a tempering effect on whatever pessi-

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Dr. Gardner gave this paper at the Play Schools Association Conference, New York City, January 24, 1953.

mism I have toward the present scene, which we are now considering. I am an optimist, but not a satisfied one—and least of all a blind one.

However, I am thoroughly convinced that nowhere in the world at any time in history has the level of child care been as high as it is in America today. Widespread programs of disease prevention—supervision of milk and food supplies, rules and regulations in regard to sanitation, well-timed immunization procedures, and recreational programs—are all designed to meet the basic physical needs of children.

I know, of course, that these do not reach every individual child, and hence fall short of our goal of universality, but withal these disease-prevention programs of ours are the marvel of the world when viewed from the distance of numberless countries that one might mention.

To move to the area of *cure* of disease in childhood, I might mention that just a short 16 years ago when I was a house pupil and resident in pediatrics, before the discovery of the modern antibiotics, we were (at least by present-day standards) practically powerless in the face of certain infectious agents. (I should say in passing that the major

emphasis in pediatric practice will probably change under the impact of these curative measures.) Finally, merely to emphasize the uniqueness and comprehensiveness of the child-care scene, I will recall to your mind that the child-guidance clinic, with its emphasis on the psychiatric care of children, is a contribution to the total program that is less than 50 years old.

Parents are conscientious

And now to reemphasize my optimism, I should state also that in spite of the fact that I am a child psychiatrist who sees at times the most flagrant evidences of the physical, emotional, social, and moral neglect of children by their parents, I am convinced that no society of parents, taken by and large, have ever been so desirous as are parents in present-day America of extending to their children—and so eager to prepare themselves to extend to their children—over-all thoughtful and scientific care.

As one views the sincere efforts of the great majority of American parents to familiarize themselves with all the tenets of good child care involved in the medical and psychiatric programs that I have outlined above,

and when one notes the eagerness and conscientiousness displayed in insuring that their children receive the benefits to be derived from such programs, one very soon gives up the easy and seemingly popular role of “parent-baiter.” (Possibly I shall be read out of the American Academy of Child Psychiatry for such heresy, but if so, I shall feel that I have been demoted for leading a much-needed crusade!)

In the light of all this, why should I not be completely contented with the contemporary scene? For I am really not content. I am not content for two reasons: First, because—as I stated above—these programs are not yet universally applied and within the reach of all parents and children; and secondly, because we in America are continually forced to use up a lot of our energy in fighting rear-guard actions against those who would either (a) modify our present programs of individuation of treatment of children; (b) prevent an expansion of them; or (c) worst of all, eliminate them entirely on the grounds that society as a whole is not responsible for carrying them out.

Before specifying the area of my discontent, I would like to bring to your attention what seems to me to be a growing tendency of the moment in regard to the general philosophy of child care. This tendency is a temporary (I hope it is temporary) swing away from programs entailing inherent democracy and individuation in child care toward those inherently totalitarian and disciplinary in nature. There is a growing distrust of that which might be termed progressive and individuated in nature.

As indicators of this undesirable reaction I would cite for you three items printed recently in one of our large metropolitan dailies:

1. The first was a reported interview with a judge of one of our leading juvenile courts, outlining the causes of the recent increase in juvenile delinquency throughout the country. The report said that the judge “attributed this intolerable situation to four factors: (1) misinformed but well-intentioned social workers; (2)

Programs for prevention of disease in children are at a high level in this country today.



police laxity on full enforcement of the law; (3) courts handicapped by pressure of modern thinking; and (4) parents." The judge also "said the situation has been developing for the past 20 years, 'or since about the time of the introduction of the philosophy that there is magic in the medical approach to cure young delinquents. This is known as the progressive attitude.'" As the treat-

It is obvious to us that these pronouncements indicate a growing distrust of our programs of individuated child care; and though a single statement does not reflect the feeling of all the representatives of any one of these three fields, there may well be a generalization of such feelings at the present time; and the struggle for ideas and ideals essentially democratic in nature against the yearning

with more problems to be solved, and we must be ready with enlightened methods to solve them. It will be well worth the price.

The repeated emergence of this opposing philosophy of child care is the source of my *general* discontent with the contemporary scene. I will list some specific areas of child life that need our attention if all children are to be accorded the comprehensive and individuated care that is my chosen measure of minimal excellence:

1. In the field of physical health more and more research and treatment programs are needed relative to (a) prenatal care of mothers; (b) care of premature infants; (c) early and adequate treatment of congenital defects; and (d) care of children who are physically handicapped as a result of infections, such as polio, that attack the central nervous system, or of handicaps resulting from the accidents sustained by children in this exceedingly dangerous (to children) world of ours. In respect to all our services, I would especially emphasize the woeful lacks in application in our rural areas. Children and mothers in these areas are definitely in the position of second-class citizens when their opportunities to secure medical care to insure life and health are compared with those within easy reach of people in urban places.

2. I would cite secondly the minimal or nonexistent facilities for mental-health care (and particularly preventive care) of children in *all* areas of the country. This applies to both the mentally handicapped child and the emotionally upset or maladjusted child.

3. In the field of education we are not yet even approaching the needed emphasis on the individual educational needs of our children. I do not refer here only to the lack of physical facilities or the lack of teachers. These shortcomings are known to you. But of equal concern is the lack of individual care of large numbers of normal children with generalized or specialized learning blocks or disabilities. Not to apply

(Continued on page 149)



We now know much more than we used to about how to cure the diseases of childhood.

ments of choice the judge urged that "we must get as tough as they are and put them where they won't be menaces to the public," and added, "We have to return to the system of reward and punishment."

2. A second item, from the field of the clergy, suggested that the maladjustments and misbehavior of children were the result solely of godlessness and urged the induction of rigid moral codes as the one best preventative or treatment.

3. The third voice was raised by a group of nationally prominent educators, who were firm in their belief that the present-day emphasis on social studies was ineffectual and a waste of time, and urged that a return to an efficient grounding in "the three R's" and academically oriented history be instituted in our schools.

for the more disciplinary totalitarian notions of child rearing is always with us.

Problems worth solving

I submit that one essential difference between totalitarian programs and democratic programs in this area is that the totalitarian programs are easier to carry out. There would be fewer problems in such a system, and problems as they arose would be handled in a swift, summary, and repressive manner. On the other hand, the very essence of our democratic, progressive program of child care is that it places a higher value upon sensible and constructive freedom of expression by the child than it does upon coercion and restraint. And to maintain this value, we must content ourselves with being faced forever

SOCIAL CASEWORK AND THE CHILD CAMPER

ADELAIDE Z. PALUMBO

CAMP has been reputed to do a child so much "good" that ideas about it have outranked those about spinach as a "must" for sturdy growth. The concentrated period of group living outdoors has been believed to supply any quantity or quality of nutrients for a child's body, mind, and soul. With the best of intentions, we caseworkers have fed camp to a child without first assessing his need to have it or his capacity to take it.

A camp vacation, of course, can be a truly enriching summer interlude in a child's life. In camping 24 hours a day he meets all kinds of spontaneous and planned opportunities for social relationships not only with other children but with adults, and for creative and educational experiences.

One major factor to remember, however, is that a child's primary group experience comes from his family, and we must not, therefore, lose sight of the fact that the child's camp stay is a temporary group placement. If we caseworkers have a part in planning a camp placement, we should accept our responsibility for knowing enough about the prospective camper, his family, and their interrelationships so that we are clear that a camp vacation is what the child needs and wants. Also we should have enough knowledge about the camp. There are camps and camps, and the fact that a camp is approved does not mean that it is

necessarily a good camp for a particular child.

Because family agencies, children's agencies, and health agencies have been sending children to camp for years, it is rare to find a caseworker who has not had some direct or indirect experience in placing children in camp.

In order to improve their practice in camp placements, some agencies have a caseworker as "camp chairman," who handles all arrangements and relations with camps, consults with their staffs, and, through visits and reports, evaluates the camps the agency will use. Others set up temporary staff committees to study the casework practice of the agency in relation to camping.

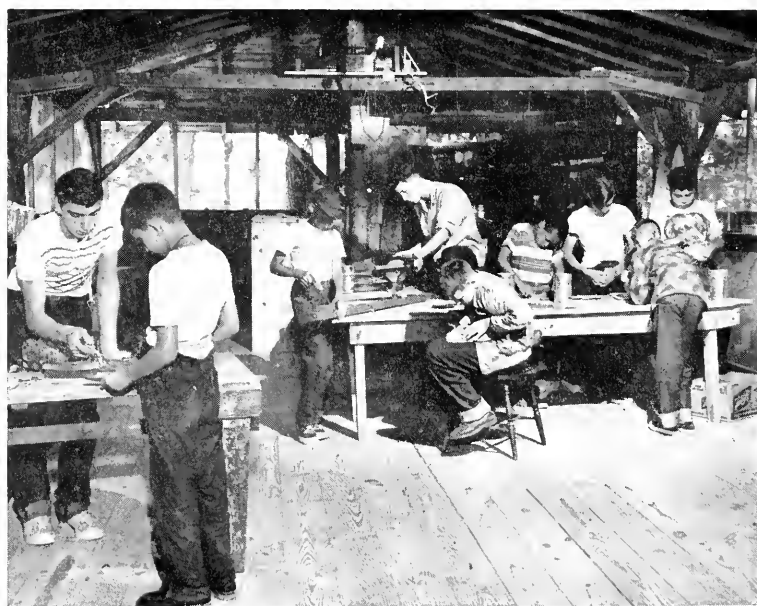
One such committee concluded that "camp placement is a casework service, which requires as good diagnostic thinking and casework planning as any service which the agency has to offer." This is a sound first principle in camp placement.

Camp life is an environmental treatment experience that we offer children with various individual or family difficulties. How can we make the most of this temporary placement for the best interests of the parents and of their children?

There is a growing trend toward working out ways and means of answering this question. Caseworkers and groupworkers who have worked in camps, and the camping organizations that have employed them, are becoming convinced that closer cooperation between camping organizations and social-work agencies is a sound and effective way to team up toward their common goal of helping children.

Social workers are now taking varied roles as camp counselor, as supervisor of counselors, and as camp-intake and follow-up worker. Insofar as we in social work take a more active part in camping programs, our understanding of children's behavior will be enriched by

In 24-hour-a-day camping a child gains spontaneous and planned opportunities for social relationships with other children and with adults, and for creative and educational experiences.



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Mrs. Palumbo's article is drawn from personal experiences in agencies in the Midwest and the East. Since 1947 she has been with the Community Service Society of New York both as a caseworker and as group therapist in its Division of Family Services and for the past 2 years in its Department of Public Interest, where she is also a contributing editor to the Community Service Society Weekly Bulletin.

more first-hand experience with both normal and maladjusted children, and we shall learn more ways by which we can improve and quicken our help to them.

The day may come when it will be more common for workers in health, education, social work, and camping to team up *in camp*. Some privately owned and operated camps, as well as organizational ones, have done this by engaging groupworkers and caseworkers, psychiatrists, psychologists, and education and recreation specialists. These workers' experience indicates that camping is as yet an untapped natural resource for dealing with the whole child. Some camps are authorized to offer accredited field experience to social-work students. Social workers who are planning to work with families and children in casework, group-work, or psychiatric agencies would do well to investigate such opportunities.

The caseworker acts as consultant on camping

The caseworker from an outside agency who is to serve as consultant to the camp of a groupwork agency should first become well acquainted with the function of the latter. This is especially important if he has never had any groupwork experience. His role may be defined by assignment: for example, he may help in the training of camp personnel, or he may be available for consultation on individual situations.

If the caseworker is on the staff of the groupwork agency he should know when to suggest closer case-work and groupwork cooperation in the over-all program. In the YWCA, for example, a caseworker, known as the "personal counselor," is available for help to any individual who comes to the "Y," or to any of the departments of the Association. She thus functions in connection with the various agency services as well as in her own line of giving individual help. This has particular value in relation to camping.

For instance, it was a chance interview between such a worker and a little girl that brought about an im-

portant improvement in the camp-application policy of a YWCA.

In the camp director's absence, I was asked to interview a 12-year-old youngster, Kathe, who came to our office during her vacation from an out-of-town boarding school. Kathe feared her camp application might be rejected, as a balance was due on her last year's bill.

She matter-of-factly explained that her aunt, who had sent her to camp, was not her legal guardian, although she was the only relative on whom she could depend. Her parents, separated by mutual consent, had never got along well enough to make a home for her.

Her father, out of town on a war job, was accustomed to sending her tuition fees directly to her school because her mother was not responsible in handling money. Unfortunately, instead of paying the camp fees in the same way, he had given the camp payment to her mother, and the camp bill was not paid.

Kathe could not bear to think she might not go to camp. She "lived" for it all year. When I said that she was with a lot of girls during the year and suggested that she might want a vacation from dormitory life, Kathe took me to task and said there was "no comparison." She described her life in a large sectarian boarding school, where she got along fairly well. Though the dormitories were large, she felt it was the best solution for her in view of her broken home.

At camp, however, there were only six beds in a cabin and she and her bunkmates had a counselor "all to themselves." The girl found living in a small group under able, relaxed leadership a happy experience to which she wanted to return. It was evident that to Kathe her bunk unit was a substitute family group.

When I asked Kathe to tell me about how she happened to go to camp in the first place, she sighed and said it was "quite a story." At the end of her school year she had returned to her aunt's home to begin her summer vacation. But her aunt told her that the hours of her war job were changeable from time to time, and

therefore she could not have Kathe with her. The next morning Kathe found her clothes packed for a "surprise" trip. She was apprehensive, yet she realized that her aunt could not possibly care for her. Although she knew her aunt would not send her "just any place," Kathe was "plenty scared," even after she had arrived at camp.

When I said it was too bad she had not known about camp and that it was a lucky break that she liked it, Kathe agreed. She "loved" camp and if she could go again she would explain about the bill to her father. I told her that the bill would need to be paid first but that I would talk to her aunt. Everything was settled later, and Kathe went to camp.

This girl's application, like most applications at that time, had been handled by mail. Not until she was interviewed in person was her problem brought to the fore. When the interviews with Kathe and with her aunt were described to an advisory committee composed of lay and professional people, they unanimously recommended that in future all camp applicants and parents have a personal interview, and they offered the services of the "personal counselor" to the camping department.

When the agency executive, the camp director, and the counselor met together to set down criteria for camp intake, they drew up two outline forms for interviews with each camper and her parent. Caseworkers on committees and groupworkers on the staff volunteered to help in the interviews, which were to be scheduled for both day and evening appointments.

Records of sample interviews held by the counselor and the camp director were examined so that they could use practical experience with the outlines in orienting interviewers. In this way the interviewers became somewhat acquainted with all phases of camp life, such as regulations, policy in handling bedwetting, food fads, and illness, and so on, so as to be prepared for parents' and campers' questions. The arrangement of the waiting room, with camp pictures, set the feeling tone of the camp project.

Through the intake interview it was possible to make early decisions on camp applications; this, in turn, helped the camp director, who had learned a good deal about the campers before they arrived. The caseworkers and groupworkers who co-operated in the project made the satisfying discovery that their purposes and goals for children were parallel and that they had more ground in common than they had been aware of before this joint experience.

In his diagnostic thinking the caseworker not only should focus one eye on the camper as an individual and the other on the group with which he is going to live, but should then accommodate both eyes to the total situation. If unconsciously the caseworker allows himself to become overidentified with the needs of the individual child he will lose sight of that child as a member of a group.

Factors like time, sex and age of campers, program, budget, and personnel may at some time enter into

York is for children of families under care of its caseworkers and its public-health nurses. Some of the youngsters who go to camp have already been receiving individual casework help.

During the camp season to which this article refers, the camp director and the caseworker were the only social workers on the camp staff and both had had groupwork and casework experience. The director, a trained and experienced groupworker, had done student casework in the Society; and the caseworker had had training and experience in groupwork and activity group therapy. The counselors were college undergraduates or graduates, except one who was a high-school student. All were on the staff for the season only.

In general, the responsibilities assigned to the caseworker in the camp were such that they could have been carried out by either a man or a woman. The caseworker was to be the liaison between the camper and the Society's caseworkers and nurses. The fact that the caseworker in a camp for boys was a woman, of course, affected her role.

As caseworker she dealt with children who had difficulties in adjusting to group life and who were referred to her by counselors for special attention. Campers came to her on their own initiative and also referred their friends. In addition she supervised the counselors regarding children and their needs. She was responsible for the use of the "camp summaries" and shared pertinent material from them with the counselors. (Camp summaries are reports sent by the agency to the camp to provide information about the individual children.)

She was available for consultation with counselors through regular conference and as needed. Through her supervision they were helped to understand to some extent the interrelationships among the children in their groups and their own emotional involvement in the experience. Although she did not attempt to go into this deeply, she was able to touch on it sufficiently to provide consider-



Camping can be an enriching interlude, especially for a well-adjusted child. Other children can often be helped by a caseworker so that they too can get the most out of camp life.

An awareness of group dynamics and some groupwork experience are desirable for a caseworker who handles intake for a camp. With this preparation he will have keener perception, for example, of the degree and kind of aggressive or withdrawn behavior that can be handled helpfully through a group experience. In a casework relationship the child and the caseworker are the only two individuals involved in the treatment interviews; but in group relationships the child, the other children, and the group leader are involved and the interaction may be more than the child or the group can accept.

an individual camp decision, but the basic consideration is the child.

Should it be in the best interests of the child and the parent for him not to go to camp, the caseworker should be responsible for following through on any necessary referral to another agency or a private resource. The camp application in itself is a helping process, and a placement that does not materialize may open the way for needed help to a child and his family from other sources.

Role of the caseworker in camp

The boys' camp operated by the Community Service Society of New

able support for counselors who had the maturity to become more aware of their involvement.

The composition of the groups that the caseworker had set up was worked out in line with the needs of the individual campers and the kind of supervision that was planned for them. The criteria for grouping helped some counselors to see the individual child as a part of the group and to see the group as a whole. For example, when the caseworker helped counselors to set up the bunk sleeping arrangements, they could foresee that a belligerent, provocative boy placed next to a passive, submissive one would set the stage for a bully and a victim, or that an all-around boy able to defend himself could be placed to better advantage to the group if he were between a shy, withdrawn boy and a fairly aggressive one.

S. R. Slavson, under whose supervision the writer carried on group therapy, suggests that camp groups be made up on the basis of "interests and quality of personalities." "Common interests," he says, "are a bridge between people * * *. They prevent isolation of individuals and fragmentation of the group."

Unfortunately, the camp summary often is not clear about a camper's interests and activities. The summary may say that the child likes music, but may not tell whether he likes to sing, or dance, or whether he can play an instrument. It may mention that he likes "sports and games" without specifying what kind, and without saying whether the child wants to be a spectator or a participant.

It is possible, however, to learn enough from the child himself and from his parent or teacher about his preferences and his responsiveness to creative ideas so that his natural interests and talents can be a means for satisfaction and achievement.

The caseworker in camp needs to be flexible and to be able to adjust his supervision of counselors to their experience and emotional equipment.

Some counselors need direct suggestions on handling individual children. Help ranges all the way from

giving very simple suggestions, such as casually taking an elusive and restless child by the hand when going to dinner, to more involved interpretation of the cause and effect of behavior. For example, the caseworker might need to interpret to a counselor how he might be trapped by a child with a neurotic need to provoke him. She could then point out to him the step-by-step process of becoming aware of this kind of behavior pattern so that he might, in the future, be better able to handle himself, the child, and his group. The caseworker has to gauge the all-around needs of the counselor in relation to his individual campers.

In the camp mentioned here, the agency caseworker was the liaison person in relationships outside the camp. She kept in close touch with the agency's caseworkers and nurses during the camp session by means of memos and telephone calls to them personally or through the agency's camp consultant.

These communications from the camp were about adjustment difficulties that might necessitate a visit from the child's caseworker or nurse, or about a pending decision to send the child home, or achievements of youngsters that merited recognition, or about any of the myriad problems of camp life, such as those concerning mail, clothing, spending money, homesickness, and anxieties about the family.

When counselors wrote their camp reports the caseworker on the camp staff added comments in regard to the child, the group, or the counselor. In situations in which she had had interviews with the child, or where the camp data were of diagnostic value, she recommended further social, medical, psychologic, or psychiatric study, or consultation with the health or casework services of the agency.

One such situation concerned a plump boy of 11, who became the butt of other campers because of his high-pitched voice and effeminate mannerisms. Desperately unhappy, he came to the caseworker to retrieve mail from the outgoing mailbox. He had written home that "this place is

awful," but he said now that he didn't mean it.

The caseworker suggested that some things about camp might be distressing to him, and he poured out his unhappiness and said the trouble was "there are too many boys."

This boy's body build was such as to raise the question of glandular imbalance. Closely coordinated work between the camp caseworker, who talked with the boy, and the family caseworker, who talked with the family, resulted in the boy's return home at the end of his first week, and he was helped to bear up under his experience. The family caseworker used the camp observations in consultation with the psychiatrist. The boy's difficulty at camp quickened the parents' concern about him, and they agreed to the recommendations for psychiatric treatment.

As would be expected, younger boys and "mother-dependent" campers frequently came to the caseworker with problems and often recreated the pattern of their mother-son relationship. One aggressive boy, who had been overprotected by his mother, would always come to the caseworker for implied "permission," whenever he was trying a new experience that he feared and wanted, such as his first overnight hike. He would usually start, "What do you say, should I go?"

When the caseworker happened to be on the swimming dock, youngsters vied with each other to show her what they could do. Adolescent boys who were sophisticated in their recreational tastes felt safe in voicing any criticism of program to her as a neutral person rather than the program director.

The caseworker in a camp lives, works, and plays with his colleagues and with the campers who are his temporary clients. He should be an outgoing person with a genuine warmth for children and an ability to share close living with others.

Professionally he should have some group-work philosophy and experience that is a part of him. An intellectual awareness of the group process is not enough. He is not a

(Continued on page 150)

FILMS ON FAMILY LIFE STIR DISCUSSION

Group leaders use educational motion pictures as a technique in parent education

ESTHER E. PREVEY, Ph.D.

"THAT'S EXACTLY what my oldest girl said when I told her to stay home. Remember, John?"

"Well, the father in the movie didn't act the way *my* husband does when *our* daughter answers back."

Talk like this is likely to start when fathers and mothers in a parent-teacher group have just seen an educational motion picture that brings up problems of family life. And if the group has a leader who does her part skillfully, both before and after the picture is shown, the group members' immediate comments usually develop into a rewarding discussion.

That is what we have found in the parent-education program of the Kansas City, Mo., public schools, in which about 100 groups of parents meet regularly with leaders who work under supervision of the schools' Director of Family Life Education.

The groups are organized by parent-teacher associations in different parts of the city, and they meet in their neighborhood schools.

Techniques vary

Parent-education leaders are women well qualified by education and by experience in working with groups of adults. A continuous in-service training program allows for consideration of subject matter and techniques of presentation.

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Dr. Prevey is at present serving as chairman of the Committee on Home and Family Life for the National Congress of Parents and Teachers.

The subjects, of course, cover wide fields, for when we talk about family life we may touch on such matters as baby-sitting; parent disagreements about bringing up children; boy-girl friendships; school homework; grandparents in the household—the myriad things that enter into family life.

As for techniques, the present article takes up only motion pictures, but the leaders use other media also to help them stimulate discussion: Books and pamphlets, tape recordings, radio, and other devices, each of which deserves a separate article. Films, however, seem especially popular.

With scores of films available, we have to select those most likely to bring about fruitful discussion. Among those we show are "Answering the Child's Why," "Children's Emotions," "Fears of Children,"

"Meeting Emotional Needs in Childhood," "Palmour Street," "Preface to a Life," "Social Development," "Why Won't Tommy Eat?" and "Your Children's Sleep." Two film lists are on sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. One is "Motion Pictures on Child Life" (Children's Bureau. 61 pp. 40 cents). The other is "Mental Health Motion Pictures" (National Institute of Mental Health. 124 pp. 30 cents). The latter includes suggestions on using films for group discussion.

Leader encourages discussion

But deciding on films is only one step toward our goal. We have found that if the parents are to get the greatest possible help from a selected movie, skillful leadership is needed, to channel the group discussion and keep it from wandering.

At the parents' meeting a leader prepares the way for the discussion by talking informally with the group before showing the picture. Since she is thoroughly familiar with the se-

This scene comes from "Preface to a Life," a film used by Kansas City's parent-education program. It was produced by the National Institute of Mental Health, Public Health Service.



quences, and has discussed them with other leaders and with the Director, she is able to help the parents look critically at the film so that they will be more ready to express their ideas later, whether they agree or disagree with its implications.

After the film is shown, the leader exerts her skill in carrying the discussion forward and bringing it to a conclusion that is satisfying to the group members because they feel that they really have gained some help that they needed.

As a step toward improving their techniques of leading discussion concerning films, leaders can refer to a memorandum prepared by the Director, which reads as follows:

THE USE OF FILMS

Educational films on child life are used as a device or technique for stimulating the discussion of family relationships, principles of mental health, and child development. They are not used for entertainment.

Preparation

The group needs adequate preparation before seeing the film, but a detailed account of what goes on in it should be avoided.

Suggestions for preparation:

1. When selecting a film, be sure to choose one in which the ages of the persons shown are related to the interests of the specific group.
2. Mention can be made of what is to be seen, as: "You will see instances of discipline" or "You will see parents' disagreement."
3. Emphasize that what the film will show will be only one segment of child development, or family relationships, and does not represent a complete lifetime, with all its ups and downs. Also stress that not all that is shown will apply or happen to every family or every child.
4. Bring to the group's attention that the film is not trying to show the only or the ideal way to handle certain situations, and that the group does not need to agree with the people in the film. (In fact, disagreement will make for more lively discussion.)
5. Relate the film to a specific topic or idea, such as emotional growth, parents' goals, importance of the child's early years.
6. Clear up points that might be misinterpreted.

Discussion

Good questions are needed to stimulate discussion after the showing of a film.

1. Avoid questions that can be answered by "yes" or "no," such as "Did you like it?"

2. Avoid opinion questions, such as "Don't you think that is a good film?" or "Didn't the mother handle that well?"

In questions concerning family relationships and personalities, avoid "It is" or "It was," and use "It could be" or "It might be."

Examples of preferred form:

"What could have made So-and-so behave as he did?"

"What might be some possible causes for behavior such as So-and-so's?"

4. Use questions that will lead the group to think:

Examples:

"What would you have done if you were So-and-so?"

"How would you have handled [Name specific situation]?"

"What could have made So-and-so as he was?" (Unhappy, angry, resentful, well adjusted, and so forth.)

Summary

1. Summarize briefly the general principles brought out in the discussion.
2. Ask the group members whether they have any other observations or criticisms.

On a "Film Evaluation Sheet" the leader records a number of items concerning each showing. This record is helpful in planning for future meetings. The sheet asks, for example, whether the group had enough time for adequate discussion of the film. It asks whether the discussion was spontaneous and spirited, or whether the leader had difficulty in keeping it going. Another point to be noted concerns devices for the purpose of starting discussion: Whether the leader asked questions—and if so what questions she asked—whether she set up buzz sessions, and so forth.

In our family-life program we find that films are a particularly valuable discussion aid. When group members analyze the problems of parents and children in a fictional family as shown on the screen, they can talk freely without revealing that some of the problems might be similar to their own. Thus they are able to discuss intimate concerns without embarrassment to anyone.

By means of our weekly leaders' meetings and such devices as our evaluation sheet we are hoping to improve our techniques for stimulating parents toward growth in relating to one another and to their children.

CONTEMPORARY SCENE

(Continued from page 143)

diagnostic and treatment measures in the cases of such children is not only educational waste; it is educational malpractice.

4. The lack of proper care and treatment of the juvenile delinquent also contributes to my discontent. Individuation of the child is probably needed more in this area than in any other. And I will state that the problem of juvenile delinquency, or rather the problems inherent in the development and expansion of suitable programs to care for these children, will never be solved on a local level, but will be solved only when the Federal Government assumes the responsibility of assisting the local areas.

I say this because every conference that has ever been held to set up programs in this area has ended on the note of emphasis that we just do not have the trained personnel to do the job required and the unhappy sequitur that moneys at the local level cannot be used to train personnel.

It follows in turn that lack of highly trained personnel in the field—and no way to train them—makes for a low prestige-value attached to persons engaged in work with juvenile delinquents. There is but one way to break this vicious cycle and provide adequate care for the delinquent child, and that is through establishment and expansion with Federal funds of training centers for the medical, psychological, social service, educational, and recreational experts that are so sorely needed. Such training programs have been sponsored in the field of mental health in the past 5 years and have recruited and trained hundreds of men and women for this important field. It could and should be done for the care of delinquent boys and girls.

5. I regret too the preposterous frontierlike attitude that persists regarding the emergence of special creative abilities in children. Such children are not specifically selected by us and their potentialities

encouraged and nurtured. On the contrary, they may very often be condemned.

It seems to me that just as our society zealously nurtures the development of future scientific personnel, we in a democratic society have every obligation to seek with equal assiduousness possible creators in the arts—and we need the educational machinery to discover such potential contributors to our culture to foster their growth.

I am totally unimpressed by the argument that such children will battle against adversity (or indeed will *need* to battle) to the point of effective creativity. And I should add too that I am chagrined that colleagues in my own field of child psychiatry are prone to view all deviance in child expression as a personality-destroying mechanism, with little or no consideration of the possibility that such atypicality may indicate—or may become—a creative deviance.

I will cease the elaborations of whatever pessimistic views I have of our contemporary scene with the added indictment that application of what we *do* know about child care—and *can do* about it—has not been extended to large areas and to large segments of our population in America. This I deplore—and I deplore even more the policy of extending such application through a process of expedient gradualism that seems to satisfy the thinking and feeling of many in our country. This thoroughly undemocratic process is the despair of us all and calls for a complete eradication of it through all the destructive means that we can apply.

In conclusion, then, these are my estimates of some of the aspects of the American scene as they relate to child care—good or bad, adequate or inadequate. I now reemphasize my original feelings, which are essentially optimistic. I am optimistic because in spite of temporary reactions that may ensue, our ideal of a universal comprehensive child-care program is as sound and as practical as the democratic system with which it is entwined.

CAMPING

(Continued from page 147)

unit head, nor an administrator; but he is closely involved in all parts of the camp program, including its health and administration phases. It is important that he maintain his personal and professional relationships in balance and that he keep these clear and distinct as the need and occasion demand. He can be a friendly person who is easy to live with and still be a respected professional person who is comfortable to work with.

Possibilities for caseworkers in camp

There well may be a role for caseworkers in many private and organizational camps, and in those operated for the special needs of physically or emotionally handicapped children. For the average comfortably adjusted boy or girl, too, caseworkers have an important role to play, for we know by experience that a little help, when needed, goes a long way with these children.

If schools of social work and camping organizations eventually develop more camp placements to offer for accredited field experience to students in casework and groupwork, both will gain. As either student workers or regular staff members these young men and women would share first-hand camp experience with their colleagues. In actual practice, a caseworker plans camp for only a few of the children under her care.

With camps as training centers for social workers, camping would develop its potential as a source of help for children, which it has yet to explore to the full.

Although social workers place children in camps for group experiences and although some social agencies operate camps, social work as a profession is not yet involved enough in camping. Not yet do camp staffs, as a rule, include social workers, either groupworkers or caseworkers. Yet a camp provides a service for children as much as does a child-guidance clinic, a casework agency, or a neighborhood center, and as such

it lies within the area of competence of social workers.

Significant trends are beginning to be apparent, however: A recognized school of social work has offered its first course in camping, and a vacation association has created the first fellowship for advanced study in social-agency camping.

Until social work as a profession takes more responsibility for camping, the practitioners must pave the way and demonstrate the need.

I hope the day is already here when more social workers are joining camp staffs in various positions from counselors on up to administrators. The more this is done, the sooner all of us will use camp experience as another means of learning about individual and group behavior of children of various ages. In a children's camp one lives with both the inner and outer world of childhood. What a natural opportunity for us, as social workers, to live and learn!

• FOR YOUR BOOKSHELF

YOUTH, THE NATION'S RICHEST RESOURCE; their education and employment needs. A report prepared by the Interdepartmental Committee on Children and Youth, of the Federal Government. 1953. 54 pp. For sale by Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 20 cents.

Today — not next year or next decade—is the time when we must use and cultivate all of our resources, human and material, if we are to survive as a democratic society, says this report, which, as its title suggests, looks on the young people of the Nation as our richest resource.

It is the responsibility of the community, primarily, to see that its young people are prepared to take their part in the world, the report maintains. To help communities fulfill this responsibility, the report presents facts on teen-agers in school and at work and on youth guidance, counseling, and placement services, and sets forth guides for communities to use in improving their services in these fields.

The guides for improving school programs suggest, among other things, that school be related to everyday living, that the needs of individual students be emphasized, and that school-administration policies be planned to serve all children; and they offer suggestions on steps that communities can take toward attaining these ends.

Similar guides to improvement are given with regard to youth-employment conditions, and youth guidance, counseling, and placement services.

Communities are urged to use the guides to learn what gaps exist in their local programs and then to survey their resources to meet the needs. After the most urgent needs have been decided on, the next step is to explore the available financial aid from State and Federal resources for fulfilling these needs.

The report suggests various channels for information and consultation concerning improvement of community programs for youth. Some of those listed are: State and local committees planning for children and youth; public and private agency officials; State youth councils; State agencies, including education departments, departments of labor, health and welfare, employment service, apprenticeship councils, and agricultural extension service; and Federal agencies with programs that concern children and youth.

Some of the services available from Federal agencies are listed, along with some helpful publications.

The report was developed during 1950 and 1951 by a Subcommittee on Youth Employment and Education, of the Interdepartmental Committee on Children and Youth.

REPRINTS AVAILABLE

A limited number of copies of the following reprints from *The Child* are available. Single copies may be had without charge until the supply is exhausted.

Aid to Dependent Children Keeps Homes Together. By Jane M. Hoey.

America Welcomes Displaced Orphan Children. By I. Evelyn Smith.

Attitudes Toward Minority Groups. By Annie Lee Davis.

Boys and Books Get Together. By Leita P. Craig.

Chicago's Public Housing Program Helps to Save Babies' Lives. By J. S. Fuerst and Rosalyn Kaplan.

Children Can Be Helped to Face Surgery. By Ruth M. Pillsbury, M.D.

Citizens Help a Juvenile Court. By Charles H. Boswell.

CALENDAR

May 1. Child Health Day.

May 1-7. National Correct Posture Week. Sponsored by the National Chiropractic Association.

May 3-9. National Hearing Week. Twenty-fifth annual observance. Information from the American Hearing Society, 817 Fourteenth Street, N.W., Washington 5, D. C.

May 3-9. National Mental Health Week. Fifth annual observance. Information from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

May 3-10. National Family Week. Eleventh annual observance, by Protestant, Catholic, and Jewish groups. Information from the National Council of the Churches of Christ, 79 East Adams Street. Chicago 3, Ill.

May 4-6. Society for Pediatric Research. Twenty-third annual meeting. Atlantic City, N. J.

May 4-8. American Psychiatric Association. One hundred and ninth annual meeting. Los Angeles, Calif.

May 5. Sixth World Health Assembly. World Health Organization. Geneva, Switzerland.

May 6. Young Women's Christian Association. Forty-sixth annual meeting of the National Board. New York, N. Y.

May 6-8. American Pediatric Society. Sixty-third annual meeting. Atlantic City, N. J.

May 10-14. Boys' Club of America. Forty-seventh national convention. Buffalo, N. Y.

May 12-16. American Association on Mental Deficiency. Seventy-seventh annual meeting. Los Angeles, Calif.

May 15-17. National Council of the Young Men's Christian Associations. Twenty-seventh annual meeting. Cincinnati, Ohio.

May 17-22. Tenth North American Assembly on YMCA Work With Youth. East Lansing, Mich.

May 18-20. National Congress of Parents and Teachers. Fifty-seventh annual convention. Oklahoma City, Okla.

May 18-22. National Tuberculosis Association. Forty-ninth annual meeting. Los Angeles, Calif.

May 24-27. National Conference of Jewish Communal Service. Fifty-fourth annual meeting. Atlantic City, N. J.

May 25-27. International Association of Governmental Labor Officials.

Thirty-sixth annual convention. Providence, R. I.

May 25-29. General Federation of Women's Clubs. Sixty-second annual convention. Washington, D. C.

May 27-29. Canadian Welfare Council. Thirty-third annual meeting. Ottawa.

May 30-31. American Diabetes Association. Thirteenth annual meeting. New York, N. Y.

May 31-June 5. National Conference of Social Work. Eightieth annual meeting. Cleveland, Ohio.

Some other organizations meeting in association with the National Conference of Social Work:

American Association of Group Workers.

American Association of Medical Social Workers.

American Association of Psychiatric Social Workers.

American Association of Social Workers.

Association for the Study of Community Organization.

Child Welfare League of America. Florence Crittenton Homes Association.

Medical Social Consultants in State and Local MCH and CC Programs (May 30).

National Association of School Social Workers.

National Association of Training Schools.

National Child Labor Committee.

National Committee on Services to Unmarried Parents.

National Federation of Settlements and Neighborhood Centers.

National Probation and Parole Association.

Regional conference, American Public Welfare Association:

May 6-8. Mountain Region. Bismarck, N. Dak.

Regional conferences, Child Welfare League of America:

May 18-19. New England Region. Swampscott, Mass.

June 10-12. Southwest Region. Denver, Colo.

Regional conference, American Public Health Association:

June 10-13. Western Branch. Los Angeles, Calif.

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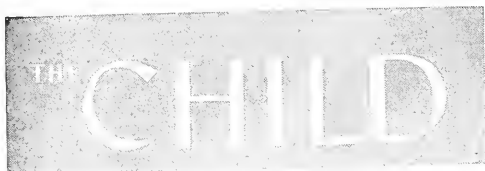
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THE CHILD

JUNE-JULY 1953



TOWARD BETTER SPEECH AND HEARING

Tennessee children are tested by State Crippled Children's Service

ROBERT M. FOOTE, M. D.

and

SYLVIA STECHER

TESTING the children of Tennessee to discover hearing and speech defects is part of an over-all State-wide program to find, treat, and rehabilitate children and adults handicapped by defects of speech and hearing.

The program was started through a movement sparked by the medical profession. This movement, in 1949, led to organization of the Tennessee Hearing and Speech Foundation, a cooperative nonprofit enterprise sponsored first by the Tennessee State Medical Association and now supported by more than 40 public and private agencies and organizations. A major function of the Foundation is to establish speech and hearing clinical centers, to which we shall refer later.

The over-all program consists of three phases: The first phase, which is the subject of this article, consists of finding the children with speech or hearing defects. The second phase consists of providing medical services in some circumstances, and also specialized clinical services, such as making detailed audiometric studies, fitting hearing aids, providing speech therapy, and so forth. These specialized services are given through hearing and speech centers provided by the Foundation. These two phases are under the direction of the Crippled Children's Service of the State Department of Public Health. The third phase, the education of children with hearing or speech defects, is the responsibility of the State Department of Education.

The part played by the Crippled Children's Service in this over-all program is the result of action by the State Legislature in 1951, redefining the term "crippled child," to include

children with speech or hearing handicaps as eligible to receive service under the State program for crippled children. The Legislature at the same time appropriated funds to finance a speech and hearing program for children.

In order to carry out its new duties, the Crippled Children's Service established a Speech and Hearing Section, with an Assistant Service Director at

21 years of age, are tested through clinics established at local health departments.

Our Speech and Hearing Section includes four senior speech and hearing consultants who hold a master's degree, and four junior speech and hearing consultants with a B.S. or an A.B. degree. The consultants travel and work in teams of two, a senior and a junior consultant.



After complete medical, audiological, and social diagnosis, a hearing aid is sometimes recommended for a child. This little boy seems to be enjoying his experience with the aid.

its head. This Section sends into each part of the State a diagnostic and screening team, consisting of two workers. The team is equipped to carry out mass or individual audiometric testing, speech recording, and other procedures to determine whether a child is handicapped by any speech or hearing defect. School children are usually tested in their own schools. Preschool children, and boys and girls out of school but under

During our first year of operation the teams traveled over the State with Nashville as their base. This year, however, we have three regional offices: one in Johnson City, one in Jackson, and one in Nashville. Two consultants are stationed in Johnson City and cover the northeastern section of the State; two in Jackson, to cover 17 western counties; and four in Nashville, to serve the counties in middle Tennessee.

We plan eventually to divide the territory up still further and to have regional offices in three more cities, Memphis, Chattanooga, and Knoxville. By next year the staff of consultants will have to be increased, since it is impossible for the present staff to cover every county in the State every year.

This year we are testing children in the counties that we did not reach last year. We also are going back to the counties that we visited last year to retest children who were found to have defects.

Finding the children

Our first year of operation was an experimental one. Three different methods of case finding were tried, to determine which was the most effective. These methods were: (1) Complete survey, as described below. (2) Referrals, by the teacher, of children who seemed to her to have speech or hearing defects. Under this plan the teachers sent to the county health department, through the education department, a list of the children who seemed to have either speech or hearing problems. In most cases the children referred were brought by teachers or parents to the local health department and we tested them there. (3) Similar referrals, by the teacher, with the aid of "symptom sheets," which list things that might indicate a speech or hearing problem. The children so referred were tested just as were those under "(2)."

Statistics were compiled concerning all three methods, and, needless to say, the complete survey by trained consultants ferreted out more problems than did either of the other methods. The classroom teacher does not have much trouble recognizing the major problems, but it is very difficult for her to detect borderline ones, and it is these children especially that we want to reach, since our program is mainly one of conservation.

Under the complete-survey procedure, which we tried in six counties and which involved testing approximately 15,000 children, we went into every school in the county and screened every child in the first eight

grades for both speech and hearing. We used a pure-tone portable screening audiometer.

Testing was done under a variety of circumstances:

In one-room schools we usually tested in the classroom, with all the children in the room at one time. This eliminated individual explanations to each child. The testing procedure was explained once, and then each child was screened in turn. In the larger schools we used the quietest room we could get: clinic, library, gymnasium, auditorium—stage and dressing rooms—lunchroom, or any other quiet location.

When a school had no electricity, which is needed for operating our equipment, we tested in a nearby church, and now and then even in a farmhouse.

In all our testing we found only one school in which we could not manage somehow to give an audiometric test. That was a one-room mountain school at the end of a precariously steep ascent. There was no electricity anywhere on the ridge, and taking the children down from the mountain was not feasible. But all in all very few of our rural schools do not have electricity, and we managed to get the children in these schools tested somehow.

An example of such a situation comes to mind, which shows how eager the teachers are to have the children tested. We were working in Fayette County in southwest Tennessee—a county with a predominantly Negro population. One school had no electricity, and so the teacher was told to take her children to another. When we arrived there we were told that the teacher had sent word that she could not get transportation for her children, but that they would walk $2\frac{1}{2}$ miles to a church where

there was electricity. We drove on to the church only to find that it was occupied—a revival was in progress—but again we had a message from the teacher. She would take her children to a farmhouse a mile down the road. We finally found her and 24 children, and we tested them in the bedroom of a tenant farmer's home. So you see there is always a way.

On the basis of our first year's findings we set up what will be our regular yearly procedure from now on. In every county we test the hearing of every child in the second, fourth, and sixth grades. In this way every child will be tested every other year. In the second grade the children are also checked for speech. We test children in any of the other grades, including high-school grades, when the teacher refers them to us.

The second, fourth, and sixth grades were selected because according to our findings more significant hearing problems occur in children in these age groups than in others.

Most children outgrow baby talk

For speech testing, the second grade was selected rather than the first, because, although many youngsters still use baby talk when they enter the first grade, they are likely to overcome this through being inschool, learning to read, talking with other children, and just growing up. If they have not overcome it by the time they reach the second grade, they probably need some special training.

The children who fail to pass the initial screening test for hearing are recalled and given a more thorough test; and, if necessary, an audiogram is made and the child is referred to a doctor. For children with speech defects the procedure is similar.

At first we used to screen all the schools and then go back to retest. But we found that this took up too much time, and so we now retest while we still are at the school.

In each county we work through the local public-health department and department of education. Several weeks before work is begun a planning meeting is held. At the meeting the medical director of the county

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This paper was presented to the Section on Testing Programs in Speech and Hearing at last year's meeting of the Speech Association of America, Cincinnati, Ohio.

health department, the public-health nurse, the school superintendent, and teaching supervisors are present. In addition anyone else who is to work on the program or who is interested in it may come—the attendance teacher, school principals, the welfare worker, and at some meetings even the county judge.

At this planning meeting the senior speech and hearing consultant explains fully the workings of the program and the services available for the children. According to the number of children to be tested, dates are set up. The public-health nurse and the teaching supervisor are usually the ones who work out the schedule for testing, and in most cases, it is the teaching supervisor who goes with us to the schools.

When we go into a county to test under this plan we prefer not to go to a school where there are fewer than 20 children to test; it takes too much time to set up our apparatus and to go from one school to another. Therefore we like to have these children brought in to one of the larger schools nearby. All the counties in which we have worked so far this year have been most cooperative about this. As many as 50 children have been brought to a central location from one school. This makes it possible for us to test more children in a day. We have found that a good daily average for two consultants, counting screening and retesting, is about 200 children.

Next year, when we hope to have more consultants, we will also retest in every school all the children for whom we made medical or clinical referrals this year. That will become our established procedure—screening for hearing all children in the second, fourth, and sixth grades, testing the speech of all second-graders, rechecking children placed under observation, checking teacher referrals from other grades, and retesting the children referred to doctors or clinics in the previous year to see whether or not their condition has improved.

When we leave a county, we give the department of education and the public-health department a complete list of the children that we have found

to have speech or hearing problems. This list includes not only children with serious difficulties, whom we have referred to a doctor or to a center, but also children with less severe problems for whom we feel that such a referral is not called for at the time, but whom we place under observation. For example, we usually put a first-grader with a speech problem under observation unless his speech is completely unintelligible. Other children are placed under observation if they have one or two slight deviations. A second-grader with a slight speech problem is checked again when he reaches the fourth grade and notation is made as to whether he has improved or not. We consider a speech problem serious enough for referral to a speech and hearing center only when it interferes with adequate communication and is causing maladjustment in the child.

Public-health nurse plays a key role

The referrals are left with the county public-health department, and it is the duty of the public-health nurse to follow these up and see that the children receive the recommended examination and treatment. Referrals are marked with a first, second, or third priority, depending upon the severity of the problem. No. 1 indicates that the child should have immediate attention; No. 2, that he needs attention, but that the need is not pressing; No. 3, that he does not need attention now but may need it in the future.

If a child has a hearing loss the nurse visits his parents, and discusses the case with them. She suggests that the child be seen by the family doctor, who may recommend a specialist if he thinks it necessary. If the family cannot afford to pay for medical service the public-health nurse completes an application for such service, which is sent to the regional office of Crippled Children's Service through which she works.

In the regional office an authorization is issued and the child is seen by one of the ear specialists who are working with us on this program. If he recommends a series of medical

treatments, Crippled Children's Service pays for these; also for surgical or radiological treatments if the specialist recommends these. (We do not provide for surgery unless the ear specialist feels that the child's hearing will be improved by it.) If the child needs a hearing aid and his family cannot afford to buy one, Crippled Children's Service will buy it for him, and if necessary, service it. If the child's hearing is impaired so much that speech training is advisable, this is made available through the facilities of the nearest hearing and speech center.

Children with organic speech problems are, of course, referred to the proper specialists. Repair of cleft palate, a condition that causes much speech difficulty, has long been a function of Crippled Children's Service. Children with cleft palate are seen by the plastic surgeon, the orthodontist, the prosthodontist, and the pediatrician, as well as the speech correctionist. Speech correction goes hand in hand with repair of the child's cleft palate.

Purely functional speech problems are referred to an ear, nose, and throat specialist before the child is admitted to the center for treatment.

We have referred several times to speech and hearing centers, and we'd like to tell a little about them.

The first one of these centers established in the State is the one at Nashville. It is housed in the Tennessee Hearing and Speech Foundation building, provided by the Vanderbilt University School of Medicine. It is located directly across the street from Vanderbilt Hospital, and it is equipped with every modern device necessary for the efficient functioning of a speech and hearing center. Last year this was the only such center we had, and service was available mainly to children within a convenient radius of Nashville.

This year another such center is in operation, in Johnson City, under the sponsorship of East Tennessee State College, and children in eastern and northeastern Tennessee are served through it.

Another center is being established

in Jackson, in Madison County, west Tennessee. This center has a wide and varied sponsorship. The building has been provided by the county—a building which, incidentally, has 18-inch concrete walls, ceilings, and floors, these are a great aid to sound-proofing. One of the leading ear specialists in Jackson is president of the Jackson Hearing and Speech Center. The city of Jackson and Madison County contributed \$2,000 apiece toward the cost of the center. Each of the 16 other west Tennessee counties whose children will receive service at this center contributed \$500, and this \$500 was raised in various and sundry ways—by PTA's and by civic clubs, and through private donations, county funds, and so forth. A group of ladies comprising the Jackson Service League undertook to get the building ready for use. They were very successful in obtaining donations of both material and labor. This center is truly a regional project.

Centers open to all

Crippled Children's Service does not operate any of these centers. Our role is merely one of stimulating interest, assisting in planning, recommending standards, and aiding in getting centers opened.

The State health department has helped by purchasing a considerable amount of equipment for each center, and for a limited time will pay the salary of one therapist. The equipment is on loan as long as the center is in operation. After a center is established we purchase service from it for children whose parents are unable to pay.

These centers offer complete speech and hearing diagnostic service, a full program of speech therapy, hearing evaluation, auditory training, speech reading (formerly called lip reading), and psychological testing. They are open to all, regardless of race, creed, color, or age. They accept children referred by private doctors, as well as those referred by Crippled Children's Service. State services for crippled children are extended only to persons under 21 years of age. However, the State Vocational Re-

habilitation Service is available to persons 21 or over.

Memphis already has its own speech and hearing center, organized about 5 years ago, and we hope eventually to have speech and hearing centers in Chattanooga and Knoxville. Then every child in the State will be within easy reach of speech and hearing service. Of all the handicapped children, those with speech handicaps can be most readily helped if help is made available.

During our first year of testing, it was frustrating at times to find so many severe speech problems and to know that nothing much could be done for the children since they were too far from the center at Nashville, and very few counties had speech correctionists. Now, however, the State Department of Education has a scholarship plan, whereby a teacher who is interested in the field of speech correction may go to summer school for four summers; thus she can qualify as a speech correctionist and get a master's degree at the same time. Each year when she returns to her county she takes on a little more responsibility. After the first summer

she works only on simple problems of articulation. The following year she takes on more serious cases, and so on. Through this system we hope to have speech correctionists in many more counties in Tennessee.

Another of our functions is participation in monthly cleft-palate clinics, which are held in Memphis, Nashville, and Knoxville. We test the child's speech and hearing at the clinic. This we usually do in the morning, and in the afternoon the child is brought before a group of specialists for complete study.

In Jackson we take part in a cerebral-palsy clinic, which is held once every 3 months.

We feel that finding children with hearing or speech defects is the foundation of Tennessee's speech and hearing program. The program aims to reach, before long, every child in the State who has a defect either in his speech or his hearing, so that no Tennessee child will be hampered by this type of defect in obtaining an education leading to eventual self-support and responsible citizenship.

This is part of the equipment used at hearing and speech centers in diagnosing. The photograph was taken at the Speech and Hearing Center, Johns Hopkins University and Hospital.



FOSTER PARENTS SPEAK UP

Children's agency welcomes their participation in planning

ESTHER S. MELTZER
and
MIRIAM WANNE

LIKE most foster-home agencies, the Jewish Children's Bureau of Cleveland for years traditionally gave an annual tea or dinner for foster parents (usually the former, out of consideration for the agency's budget).

The purpose of the annual social event was twofold: (1) To give foster parents an opportunity for identification as a group and as a part of a larger whole, and (2) to give the agency staff and board an opportunity to give recognition to them for the important role they play in the agency's service to children.

But this once-a-year social gathering, we began to realize, was doing nothing to help the foster parents deal with their difficulties and uncertainties regarding their relationship to the agency, which they knew only through their contacts with various caseworkers.

Before it was time to plan the 1948 annual get-together, we of the agency realized that just another social meeting would not suffice. We felt that foster parents ought to be given a chance to know more about the whys of the work in which they and we were mutually engaged. They needed to know more about such things as why some parents cannot provide homes for their children, so that the children need foster care; why the agency functions as it does; why children behave as they do; why foster children at times are very much like one's own children and why at other times they are incomprehensible strangers.

We decided to offer a brief study course made up of lectures on child

development and child behavior, and we took our plans to our case consultant, who had done considerable work in group education. After a vigorous discussion, we recognized that we had again fallen into the standard attitude of workers toward foster parents, that is, thrusting the foster parents into the role of passive onlookers. Such a program would not encourage striving for answers to questions.

Our next plan was a variation of our original proposal. This time we decided to hold a series of monthly meetings at which there would be no outside speakers. The foster parents themselves would determine the range and depth of the discussion. A planning committee composed of two staff members and seven or eight foster parents would meet before each general meeting to draw up the agenda. The case consultant would lead the group discussion, and after each meeting a staff committee would analyze the progress we had made. What we would deliberately seek would be an exchange of knowledge and experience that should lead us all to a better understanding of why foster-home placement is needed for some children and how foster parents

ESTHER S. MELTZER is now with the Spence-Chapin Adoption Service, New York City. Before that she was a district supervisor with the Jewish Family and Children's Bureau of Boston. At the time the program described here was started, Miss Meltzer was a caseworker with the Jewish Children's Bureau of Cleveland. This article is based primarily on a paper that Miss Meltzer gave at the Ohio State Welfare Conference when the program of foster-parent meetings had been going on about a year and a half. The article is planned to show the dynamics of the program's start.

MIRIAM WANNE, who is a caseworker with the Jewish Children's Bureau of Cleveland, has contributed additional material to show some of the later developments in the foster-parent meetings.

Concerning the more recent stages of the program much still remains to be told.

and caseworkers can best work together for the greatest benefit of these children.

The meetings were to be held at night so that foster fathers, too, could come.

This plan was put into effect in April 1948. The response of the foster parents was electrifying. All of us—foster parents and staff—were fired with enthusiasm to wrest from each meeting the maximum in learning from one another and in finding out how to translate our knowledge into more fruitful cooperative work.

For members of the planning committee we chose some foster parents who had had long service with the agency and whose foster children were representative, in age and type, of the children generally served by the agency. About half these couples had European children in their homes. We sought people who would be able to speak up in the group without hesitation or embarrassment, since the committee members would act as co-leaders in each discussion and at times would have to take a definite assignment to prepare to focus discussion on a certain point. We asked the staff to recommend foster parents who in their opinion measured up to these requirements. We included foster fathers as well as foster mothers.

The Sterns were our first and unanimous choice, a couple in their early forties, with two children of their own, a boy of 13 and a girl of 4. They were then entering their third year as foster parents and had in their home four foster children. They were people of moderate means, with only a sketchy formal education, and they had an earthy, natural dignity.

Mrs. Stern was a truly maternal person, who liked children. She saw in foster parenthood the opportunity to provide companionship for her own youngsters, as well as to add to the family income. During her contact with the agency she had demonstrated capacity to serve youngsters of varying capacities and behavior patterns. She was completely identified with the agency and eager to participate in planning. In spite of

the assurance she had of the agency's confidence in her, she found it difficult to express negative feelings about the children or to take exception to the agency's planning for them.

Mr. and Mrs. Hart were also among our oldest foster parents in length of service. They too were in their early forties, and they had one adolescent daughter. They had been outstandingly successful with their one foster child over a period of several years. Mrs. Hart, characteristically, was the dominant member of the family. She was a person who expressed herself easily. There was a forthrightness about her comments that was provocative and challenging. Midway in our program the Harts dropped out, partly because their foster daughter became financially independent. Another factor in the Harts' withdrawal, we believe, was the fact that Mrs. Hart's outspokenness in the meetings created negative reactions in the group toward Mrs. Hart, which she could not tolerate.

The Harts were replaced by the Pearls, a younger couple with two small girls of their own and one foster child, an adolescent girl.

Mrs. Pearl, like Mrs. Hart, was the dominant person in the family group, but Mr. Pearl was more articulate than Mr. Hart and expressed himself more freely in the group. Mrs. Pearl, a practical, thoughtful, even-tempered person, contributed a matter-of-fact objective mood to committee meetings.

European child welcomed

Mr. and Mrs. Robins were of the newer foster-parent group, the post-war applicants. They were in their middle thirties, with three children of their own. Their foster child was a displaced European girl. Mr. Robins' experience with the Army of Occupation in Germany, when he came in contact with the "lost" children in the concentration camps, stimulated his interest in providing a home for a youngster from Europe. He was a quiet young man, apparently secure in his familial and marital relation-



A good foster mother gives the child the same personal care she would give her own child.

ships. Mrs. Robins shared her husband's interest in serving, but she was a less relaxed person and one more concerned with matching reality to the ideal. Their earnestness bore fruit in the success they had with the displaced youngster they took into their home.

The Millers could be described as the most challengingly outspoken of our foster parents. They had an intense interest in the agency's program, and Mrs. Miller, active in Jewish community life, had a keen understanding of the professional point of view and consciously tries to make use of it in her work as a foster parent. They had begun to provide an infant home for us about 10 years before this program began, and, after a lapse of more than 5 years, applied again, this time for adolescent foster children. We now use their home as a small group home for children of all ages.

Mrs. Tager was a woman in her late 50's, bright but unschooled, with real liking for children and sensitivity to their needs, but little interest in or concern about the agency's concepts. She "indulged" the workers just as she did a foster child. She at the same time demonstrated tremendous tolerance and warmth for a youngster with serious behavior difficulties.

This then was really the beginning of our program—a program that falls into three distinct periods. The first,

May to July 1948, was a period of groping and free discussion; the second, October 1948 to July 1949, was the period when the areas of interest and concern were more clearly identified and formulated; and the third, October 1949 to the present, when foster parents have participated actively in the selection of the subjects to be considered and in long-range planning of discussions. The foster-parent meetings today are much more the group's own program than was possible at the outset, because today we have in the group a large enough nucleus of foster parents who have been active in the program and through it have gained experience in self-scrutiny and self-expression, so that continuity and direction can stem from the group.

When we suggested the plan of monthly foster-parent meetings to the group of four couples, Mrs. Stern, always eager to express approval of the agency, thought it would be a wonderful idea. Mrs. Robins wanted to know the precise arrangements, and her husband said it was a good plan if we could really work it up.

Then Mrs. Hart spoke her mind, prefacing her remarks with her usual "You won't like what I'm going to say." She wanted to know how we could expect foster parents to be completely honest, to tell what problems they really have, and to confront the caseworkers and the agency openly with criticism of their

methods. It might be a good idea, she said, like many of the agency's other ideas, but she for one doubted that it would work. Then, as an afterthought she quietly remarked that it wouldn't hurt to try.

A general, free-for-all discussion followed, with the foster parents commiserating with one another on their "problems" and occasionally remembering to reassure the two staff members who were present with: "We think the agency does a wonderful thing, the way you give the children everything."

First general meeting planned

After some time, the chairman remarked that what we hoped to do in a more organized fashion in the larger meeting had been done here in some slight degree—we had found some mutual problems and questions and had engaged in a lively discussion of them. The value such meetings might have for all of us was pointed out. The kind of frankness Mrs. Hart had displayed was good, and we hoped that eventually all our foster parents would feel equally free to share their reactions and feelings about the work we were doing together. Gradually, as each member expressed himself, enthusiasm seemed to develop within the group about the program we had suggested, and the committee began to plan thoughtfully for the first general meeting.

Our first meetings were held in the homes of staff members. A generally social air predominated and a note of informality developed around refreshments served at the end of each meeting.

About 30 foster parents came to the first meeting. We were struck by their reaction to one another. Because of the close ties in Cleveland's Jewish community, few of the group were really strangers to one another. Visible on many of their faces was the question that one or two blurted out. "Are you a foster parent, too?" We saw some instances of bristling embarrassment, but after the first brief period of constraint and tension the group relaxed.

The group was formally greeted by our director, who stressed the im-

portance of the work in which we were mutually engaged and expressed the hope that our meetings together would prove helpful in improving the quality of our service to children. The case consultant then took over the meeting. He outlined the purpose of the meeting as seen by our staff and the group of foster parents who had met with the staff in an advisory capacity; and then he encouraged discussion and questions on the proposed program and on our work in general.

What questions did they have about the agency, about the children, about their work as foster parents? The first uneasy response was volunteered by one of the committee members, and the way was opened. How can you satisfy an adolescent girl about the amount of clothing she asks for? Why do the children seem to resent the agency at times? Why is it you can say anything you want to your own children, but can't to a foster child? Why are there certain rules about parents visiting? And wouldn't it be better if some parents didn't visit at all? Just what do the social workers do with the children in their offices?

There were comments, tentative at first, then more and more bold. Some foster parents seemed fearful of implying any criticism of the agency and were lyrical in their declaration that all is right with the foster child's world so long as he is in the foster home; others, of a more aggressive bent, sounded a critical note. The greater number, however, were silent in the meeting, but later, over the coffee cups, expressed interest in further meetings.

Planning committee meets again

At the second meeting of the planning committee, only cautious approval of the first general meeting was expressed. Each committee member launched into a discussion of his own experiences with his specific foster child and caseworker, as though testing the tolerance of the group for real questioning and negative feelings. It was only after free expression had been given to this that the group was able to settle down to considering a topic for the next gen-

eral meeting. The subject which seemed of most urgent interest to the group was "the caseworker": What is the role of the caseworker? What happens in the individual conferences between the caseworker and the child? Why does the child so often come away from his contacts with the caseworker so upset? And on and on.

Thus "the caseworker" became the subject of the second general meeting. For the group to understand the role of the caseworker it was felt that it would be important and helpful for them to study, not only the caseworker, but themselves, in relation to the total agency structure and network of services. The director therefore was asked to explain the agency organization to the group. He explained the foster-home-care department of the agency and its relationship to the agency's institution and its day nursery. He explained then, in considerable detail, the specific role and training of the caseworker, her responsibility in approving and supervising foster homes, and the importance of her work with children who are in placement, and with their parents. He mentioned, too, the State licensing procedures.

The foster parents then were encouraged to give their impression of the role and function of the caseworker. One foster parent described the caseworker as a "referee" between the foster parent and the child; another spoke of the caseworker as the person to whom the child can go "to get things off his chest"; still another saw the caseworker as the person whom the child "plays against" the foster parents. It was apparent that the foster parents had much question about the need for and the usefulness of the caseworker. There was some suggestion, even, that the caseworker was a source of confusion and disturbance to all concerned, particularly in such matters as allowances, jobs, and dating.

The discussion branched into a consideration of why and how children come to the attention of the agency and how parents and chil-

children are helped to use its services. There was discussion, too, of the part the caseworker plays in the selection of foster homes. And out of this evolved the question: "Why do people become foster parents?" a basic question which made up one of the many recurrent themes of the meetings that followed, but one which at this point had in it a bombshell quality.

A foster mother who had one of our babies in her home replied, "We want to help children." Mrs. Tager said, "We want to do a good deed, like the Bible says." But our forthright Mrs. Hart stated bluntly, "We do it for selfish reasons. We can't love the children because we don't know them before they come to us. I had only one child and I wanted a companion for her, but we also do it for the money; let's not forget that!"

There was an audible silence, a momentary gasping for breath as though reacting to shock, and then an outburst of protestation. One foster mother went so far as to assert vehemently that the agency should not accept foster parents who said they were interested in the money. Others weren't sure. One ventured that if a foster mother was honest enough to indicate that she was interested in the money, when that was the situation, she would also be honest with the child. She thought that if the family met the agency's other qualifications, their interest in finances should not disqualify them.

It was at this point that the discussion leader raised the question about whether it was so wrong to be interested in earning extra money. The rest of us, referring to caseworkers and other members of the staff, get paid for what we do—why should there be any question about money as a motive for foster parenthood? Being paid does not take away from the special nature of the job; nor does it matter that while we may be earning extra money we may at the same time be meeting other needs, such as the need for companionship.

After this outburst and sorting out of feelings, it seemed that the dis-



Many factors, of course, enter into a couple's reasons for taking a foster child into their home. Often the most important factor is enjoyment of the child's companionship.

cussion of what goes into the agency's selection of foster parents, which followed, took on new meaning. The group was obviously impressed and intrigued with the fact that the staff saw foster parenthood as a form of employment and felt that work should be paid for. They became curious about how the agency decided which couples to accept and which to reject. This gave the staff an opportunity to discuss our intake procedures, our study of the foster homes, and our use of references.

Over the coffee cups after this meeting there was more than informality and cordiality. There was an air of elation as foster parents talked with other foster parents and with agency staff. As one foster mother put it: "I never knew so much time and thought went into the work we are doing together." Staff members, in their home calls after the meeting, were unanimous in their feeling that "something had happened" to level away the barrier that had always seemed to exist between foster parents and staff. There was a quality of togetherness that had never been so apparent before. There was a clearer understanding on the part of foster parents of their place in the total agency organization, a new feeling of status, and of appreciation of the real importance of the job they were doing.

Our third meeting continued what

might be called our stream-of-consciousness discussion. It was held at the beginning of the summer-vacation period. The staff committee planned it as a party. The one bit of serious business would be in the form of a parlor game. We presented to the group six situations: Three in which a foster child needed placement, and three in which foster parents were awaiting placement of the kind of child they had requested. We asked our foster parents to match children to homes. From the discussion evolved such questions as:

Could you love a foster child as much as you love your own? Perhaps not, but you could try not to show favoritism in front of the children.

A foster child ought to be placed in a home where he would not have to compete with an "own" child near his age.

Maybe the agency does have a hard time if we foster parents limit them too exactly in the kind of foster children we ask for.

In the kind of things they expect and demand from adults, in the way they talk to adults, foster children aren't much different from our own children.

An adolescent girl may be better off with a young foster mother, who can remember her adolescence and act as an older sister, rather than with a motherly older woman.

Perhaps there is not much difference between the American child and the displaced European child.

The meeting ended with eagerly expressed anticipation of the beginning of the series in the fall.

(To be concluded in the next issue)

FOR MORE REWARDING SUMMER RECREATION

A city health department provides consultation services to day camps

LILLIAN MARGOLIN

IN A CROWDED CITY, children need opportunities for the kinds of summer recreation that are safer, more healthful, and more constructive than haphazard play on the street. During the school-vacation months, many groups and some individuals in New York City attempt to supply such opportunities by offering children a wide variety of organized recreational programs, known in general as day camps. It is estimated that nearly 600 such camps are open in the city for about 8 weeks each summer. (These do not include year-round day-care centers, nor mass recreation programs such as the vacation playgrounds provided by the Board of Education and by the Department of Parks—programs in which the children may not be regularly enrolled.)

Sponsorship varies

Such organizations as settlement houses, Boy Scouts and Girl Scouts, religious groups, and various social agencies sponsor some of the day camps. The municipal government is responsible for some, through its Board of Education, its Housing Authority, and its Youth Board. Others are operated by private individuals, and by cooperative groups of parents. Some landlords have established day camps for the children of their tenants. The large majority of the camps are run by nonprofit groups; less than a quarter of them are commercial.

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Each summer at least 100,000 children under 16 take part in these day-camp programs. With such a large number of children involved, the Bureau of Child Health of the city's Department of Health naturally is concerned about their physical, mental, and emotional health. And for the past 2 years the Bureau's Division of Day Care and Foster Homes has had a special Day Camp

this service we also collect complete data on the camps, such as their location, the number and ages of children attending, the number and qualifications of staff, the hours per session and number of sessions per week and the fees paid by parents.

Because changes cannot be made easily while the children are at the camps, our consultation service is most effective when given during the



A good day camp offers a relaxed atmosphere, where children may use their own initiative.

Unit, including three social group workers and a public-health nurse. This Unit works to help camp operators and directors offer children experiences that are safe, healthful, and happy.

As a step in this direction we of the Day Camp Unit observe and evaluate the programs while they are in operation, and give year-round consultation service. To help us give

periods of pre-season planning and post-season evaluation.

In evaluating the day-camp programs and recommending changes, we have found helpful a set of minimum standards that have been recommended by the Welfare and Health Council of New York City. These standards, dealing with health services, physical facilities, sanitation, food, program, transportation, per-

sonnel, insurance, and records, were described in *The Child*, October 1951.

Besides giving consultation service to the directors of individual camps, the staff members of the Day Camp Unit hold conferences with representatives of the large organizations whose affiliates conduct day-camp programs, and of the private day-camp associations. At such a meeting we analyze the particular situation of the group and seek solutions to its problems; we enlist its cooperation in improving practices in its camps; we explain the recommended standards, distribute literature, and answer questions.

In our consultations we make every effort to preserve the individuality of each camp. The help given depends partly on the basic philosophy of the

tempt to stereotype the programs, nor do we assume that only one method of operation is sound.

With some camps it is necessary for us to start our consultation with recommendations concerning basic minimum needs, such as for maintaining cleanliness, providing an adequate number of toilets and wash-basins, controlling flies and vermin, providing shelter for the children during inclement weather, and arranging for them to have wholesome food.

Other camps may not need help in such elementary matters, but may need help in developing a sound health program. To the director of such a camp we might explain the value of pre-season health examinations for campers and staff. Also we

might work out methods for daily inspection to detect signs of illness, and plan for dealing with accidents and sudden illness. We might suggest routines including rest periods, and offer ideas for interesting and nutritious meals.

Often, after the consultant has made recommendations of this kind to a camp director, other important aspects of the program will come under discussion, such as camp personnel. Our Unit constantly stresses the importance of having warm, friendly, mature staff members, who understand the growth and behavior of children. We emphasize that the previous training of these workers should include some study in the field of education, or of recreation, or of social work, as well as experience with children in groups.

The Unit realizes that it is not always enough to convince a camp director that a day camp should have well-qualified personnel; it is often desirable also to help him make the best use of the funds budgeted for staff salaries, and to suggest sources for recruiting workers. The consultants are ready also to help a director develop in-service training programs and methods of supervision, and to assist with personnel practices in general.

To meet needs of different children

Planning for staff is necessarily related to the number and the age group of children for whom the worker will take responsibility, as well as to the program he will conduct. In discussing the daily routines of the group, the consultant and the director will give consideration to the need for balance between activities and quiet intervals; and to the need for offering a variety of experiences to meet the needs of children with different interests. These experiences might include swimming, group games, arts and crafts, hikes, picnics, study of nature lore, music, dramatics, and so forth.

"Program" includes the entire range of activities, relationships, interactions, and experiences, both individual and group, which the director plans and carries out with the



Mature, creative leadership is an essential for a successful day-camp program for children.

agency that operates the camp, the type of program, and the director's readiness to accept help. Each camp has its own set of problems, its own philosophy and objectives. Despite this variety, however, some basic common denominators of sound practice and principles of good living and good health apply to all the camps, for they apply to all children in all situations. Our Unit makes no at-

tempt to show why the camp needs to have a physician study the results of these examinations and make recommendations concerning them. Another point on which we might advise the director is in regard to making provision for individual children with specialized needs, such as a child with epilepsy, or with a crippling condition, or with an emotional disturbance. Together with the director we

help of the counselor to meet the needs of the individuals and the group.

To help with program development, the Day Camp Unit compiles reading lists and offers equipment lists, and also makes specific suggestions, according to the location and resources of the particular camp.

In a play school in a congested slum area, for example, a plan was developed through joint conferences for regular weekly trips to State parks, to farms, to the agency's resident camp, and to other rural spots. For many of these children these trips were their only opportunity to know at first hand the feel of earth and grass, to wade in a brook, to see a frog or a salamander hop out of a puddle, to climb a tree, and to know the freedom of unencumbered space.

Conditions improve

An earnest attempt is made by the consultants to consider the particular problems of a group, in relation to limitations of physical facilities, restricted funds, location of the camp, and the nature and extent of the service, as well as the needs of the community. At the suggestion of a consultant, concrete assistance has been given in many situations by the Bureaus of Sanitary Engineering and Sanitary Inspections, both of the Department of Health. Advice is given by the representatives of these bureaus on how to make the best use of what is available, and this, of course, need not result in large financial expenditures. Methods of obtaining improved light and ventilation are suggested, along with procedures for sanitary maintenance, for proper garbage disposal, and for efficient dishwashing and food storage. The know-how of experts has repeatedly resulted in improved conditions.

Representatives of the Department of Health's Bureau of Nutrition are also called in by our consultants to advise many directors of day camps. Again, no stereotyped or rigid procedures are suggested by these nutritionists. Many factors are taken into consideration in making recommendations concerning the children's nutrition. The agency's food budget is

taken into account, as well as the cultural habits and needs of the children served, and the camp's facilities for cooking and serving food. Many agencies are thus helped to provide interesting, well-balanced, nutritious meals for the children at a reasonable cost. Since in some camps the children bring box lunches from home, the Day Camp Unit, in cooperation with the Bureau of Nutrition, has published a leaflet entitled "Box Lunches and Snacks in Day Camps and Summer Group Programs." This pamphlet is available to the camps for distribution to parents. In addition the Unit consultants and the nutritionists meet frequently with parent groups to discuss the food needs of children in day camps.

The work of the Unit is helped immeasurably through the broad resources of the Department of Health. Specialized assistance is available from other bureaus of the Department—not only the three bureaus mentioned previously, but also the Bureaus of School Health, Public Health Nursing, Public Health Education, Preventable Diseases, Records and Statistics, Foods and Drugs, and

the unit devoted to public relations and publicity.

Our consultation service is in effect an educational process, and we establish ongoing relationships with many groups. In some instances the camp operators request our help; in others the consultant takes the initiative. In no case has any group refused to discuss its operation of a camp or to permit observation or inspection.

We prepare for follow-up

The information secured during consultation conferences and observation visits is noted in case records. These records enable us to compile all known data, to give a complete picture of each agency concerned, in order to help in follow-up in the future and in over-all comparative studies.

During the months of July and August the Unit's year-round staff of four consultants is augmented by a part-time staff of school physicians assigned by the Department of Health, and by several sanitary inspectors. This staff, working sometimes in teams, sometimes individually, carries on carefully planned field visits. The physicians observe, evaluate, and make recommendations re-

Each summer 100,000 New York City children under 16 go to day camps. And the city's Department of Health is concerned about their physical, mental, and emotional health.



garding the health program; the sanitary inspectors concentrate their attention on sanitation and physical facilities; the consultants observe all aspects of the program. After each visit to a camp, a conference is held with the director or other person in charge of the camp, an evaluation is given, and recommendations made. We follow each visit with a letter summarizing the recommendations.

Standards and practices in day camps can be improved only as parents become aware of the need for such improvement. It is therefore necessary to keep parents informed about good standards and the value of having good programs.

Most parents have at least some concern about the need for clean surroundings, attractive facilities, and sufficient, nutritious food. But they are somewhat less aware of what constitutes a creative, well-rounded, well-balanced program; what qualifications a competent staff should have; what materials and equipment ought to be available. Parents need to be kept informed about new concepts of child development and modern methods of recreational programming.

Some parents do not realize how a highly competitive atmosphere, for example, affects their youngsters. In fact parents themselves frequently insist that their children bring home evidence of their accomplishments in the form of such things as a finished ash tray or a decorative pie plate; that they receive marks of achievement in medals and awards; and that their interest and enthusiasm be maintained by spectacular events such as carnivals.

Some parents, remembering their own camp experience, demand for their children the same regimented, readymade, overorganized programs they have known about in the past.

When parents understand the fundamental needs of children, they will not be satisfied unless the program offers a relaxed, informal atmosphere, where children are permitted to use their own initiative, where there are opportunities for adventure, where the activities are interesting but not predigested and

routinized, and where the leadership is mature and creative.

The Day Camp Unit has tried to spread these ideas by means of meetings with parents' associations; through careful guidance of parent cooperatives that sponsor day-camp programs; through radio broadcasting and newspaper publicity; and through preparation and distribution of printed materials. It should be noted that parents have been very receptive to information about acceptable standards, are extremely eager to be informed, and are constantly seeking help in selecting day camps for their children. The Department of Health's folder, "Pointers for Parents," which lists factors to be considered in picking a summer day camp for children, has been widely used.

As a result of the keen interest of various associations and councils concerned with recreation programs for children, our Day Camp Unit receives a great deal of help. These groups help to locate and identify camps; they distribute the pamphlets that the Department prepares for camp operators and for parents; and they help to publicize the recommended standards. They also explain the work of the Day Camp Unit to their affiliates, and they make valuable suggestions to the Unit as to methods of approaching the problem as a whole. These groups have organized conferences and panels on day camping and similar programs, and have invited staff members of the Unit to take part.

Toward raising standards

In offering consultation service to the many day camps in the City of New York, the Day Camp Unit has worked to meet the needs of parents, of operating groups, of community agencies, and especially of the children attending these camps. Our experience shows that such service, given by experienced professional workers who are concerned with all aspects of recreational programs for children, is one way to bridge the gap between theory and practice, and is a practical approach toward raising day-camp standards.

• FOR YOUR BOOKSHELF

RESIDENTIAL TREATMENT OF EMOTIONALLY DISTURBED CHILDREN; a descriptive study. By Joseph H. Reid and Helen R. Hagan. Child Welfare League of America, 24 West Fortieth Street, New York 18, N. Y. 1952. 313 pp. \$3.50.

In this report of 12 centers for treatment of children with severe personality disorders the Child Welfare League of America gives a detailed description of each center, written by a study team that spent 1 to 3 weeks at the center, observing practice, interviewing key personnel, and reading reports. Each report includes also an evaluation or critique, written by the center's director.

These descriptions offer readers an opportunity to evaluate programs under different types of auspices. Thus, the report should be useful in promoting better understanding of residential clinical services and of the various studies of such services.

Treatment in residence of emotionally disturbed children is the major function of each of the 12 centers selected for study. Each provides direct psychotherapy integrated with a therapeutic living milieu. Each has control over what children should be admitted. All are considered by the workers who made the study as representative of the field. "The number of treatment centers in the United States, other than these 12, is not large," says the report, "and few, it is believed, have developed resources comparable to those described here."

Seven of the 12 centers can be considered medical programs and are administered by physicians. Five are social-agency programs, administered by social workers. Some of the programs were established principally for disturbed children for whom foster care also must be provided. Other programs assume no responsibility for the child's foster-care needs beyond the period he is in treatment.

Differences also may be seen between centers that offer essentially service programs and those that have a major training and research responsibility. A later publication of the Child Welfare League of America will analyze and evaluate some of these differences in function and organization.

RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN; a listing. Federal Security Agency (now the Department of Health, Education, and Welfare), Social Security Administration, Children's Bureau. 1952. 78 pp. 25 cents. For sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

To obtain information that would be helpful in answering questions from agencies and parents about programs for children with emotional disturbances, the Children's Bureau has assembled information from 36 centers whose directors reported that the center's primary purpose was treatment of emotionally disturbed children. The Bureau has listed these 36 organizations, along with a brief description of the services, staff, and facilities of each, in the hope that it will be helpful to professional workers using these services.

The information reflects the centers' services as of the spring of 1952. No attempt has been made to evaluate the programs, and inclusion of them in this directory does not constitute an endorsement by the Children's Bureau.

AN APPROACH TO MEASURING RESULTS IN SOCIAL WORK; a report on the Michigan reconnaissance study of evaluative research in social work sponsored by the Michigan Welfare League. By David G. French. Columbia University Press, New York. 1952. 178 pp. \$3.

This study will be of interest and value to all persons—lay and professional—who have had occasion to ask one or more of the following questions: "Are people being benefited by social-work services in the way they need to be benefited? Is the money which the community is investing in social-work services producing results that justify continuing or extending these services? What kinds of improvements are possible in making social-work services more effective?" Although the study does not purport to answer these questions, it is directed toward a better understanding of what is involved in obtaining the answers. Because the report is written with clarity and with a notable absence of technical jargon, it may be read with ease and profit by both research and nonresearch people.

Rather than undertake another venture in evaluating some aspect of

social service, the Michigan Welfare Board, which sponsored the study, decided in favor of the necessity of learning more about the basic issues and problems involved in measuring the effectiveness of practice. In fulfilling this charge, Mr. French analyzes critically past efforts at evaluation, the obstacles which these efforts have met, and the many considerations to be faced in planning for a continuing program of evaluative research. The material for this "reconnaissance" was obtained from a review and careful study of the literature on social work and social-work research, supplemented by a series of individual and group conferences designed to elicit material not available in printed form.

The findings of this exploratory study indicate not only that those responsible for social-work programs have many questions about the effectiveness of welfare services, but that they look to research for the answers. A review of the questions raised by social workers brought out that some may appropriately be answered by research; others not.

Questions about the goals and the values of welfare services must be considered by means other than research. As a matter of fact, one of the greatest obstacles to evaluative studies has been the lack of agreement about goals. Evaluation of practice can only be in terms of the ends which it seeks for both the client and the community. Others among the questions raised by social workers can ultimately be answered by objective research.

Mr. French's material clarifies two essential tasks which come before research as such: (1) The need to make explicit the assumptions and theories on which social-work practice is based; and (2) the need to phrase the questions in research terms and to organize them into a proper sequence.

Assuming that these tasks can and will be accomplished, the next steps in a program of evaluative research are, in Mr. French's opinion: (1) Analyzing the problems with which the service deals; (2) describing and standardizing the service; (3) measuring the degree of change brought about by the application of the service; and (4) determining whether the change observed is the result of the service or is due to some other cause. The realization of such a program will require, according to the author, interchange of ideas and skills among administrators, practitioners, social scientists, and social-work research workers.

Research into the effectiveness of social-work practice requires many things: (1) A desire for the answers, (2) funds, (3) know-how—to mention a few. More than anything else, however, an objective evaluation of social work demands a willingness to face basic issues and to raise fundamental, and sometimes unsettling, questions. Mr. French has done a real service in making this very clear.

Sophie T. Cambria, Ph.D.
Hunter College, New York City

NOTE: Although this report deals with the measurement of social work, it contains much that will be of interest to those concerned with public-health services. Similar needs for measurement of results, justification of expenditure, and increasing effectiveness exist in both fields. And, as Mr. French says, certain steps are essential to evaluative thinking, whatever the subject under consideration.

Marian M. Crane, M.D.

RECIPES FOR NURSERY SCHOOLS AND OTHER GROUP CARE CENTERS. Compiled by Edna Mohr. Elizabeth McCormick Memorial Fund, 848 North Dearborn Street, Chicago 10, Ill. 1951. Processed. 52 pp. 50 cents.

Recipes that have been used successfully in many nursery schools are offered in this publication to help directors of child-care centers and their cooks. The recipes give the amounts of ingredients necessary for serving 25, 50, and 100 children.

Catherine M. Leamy

IN THE NEWS

Juvenile delinquency. Through a new grant from the Field Foundation, the life of the Special Juvenile Delinquency Project that is working closely with the Children's Bureau has been extended until January 1, 1954. Supported by voluntary contributions disbursed by the Child Welfare League of America, the Project aims to improve treatment services for delinquent children.

For its final 6 months' activity, with an enlarged staff, the Project hopes to bring to conclusion the work it has undertaken along with the Juvenile Delinquency Branch of the Bureau in developing new standards—or statements of desirable practice—for training schools for delinquent children, juvenile courts, and juve-

nile-police services. Specialists from all over the country are cooperating in this work.

Addition of the new staff will permit the Project to step up its cooperative efforts with the various National, State, and local groups that have been participating in the campaign for better services for delinquent children.

The Project grew out of a Conference on Delinquency Control held by the Children's Bureau in Washington in April 1952. It is hoped that the Project can conclude by recalling the members of this 1952 conference in order to report to them on work accomplished and what remains to be done.

SUMMER COURSES

Columbia University. New York School of Social Work. New York 28, N. Y.

Two series of summer institutes in social work. Some of the courses: Series I (for graduates of schools of social work): Social treatment with the adolescent; Social work with the ill and handicapped. Series II: The psychosocial development of the normal child; Casework with unmarried mothers; and Casework with children in their own homes and in substitute homes. Series I, July 6-17. Series II, July 20-31.

Louisiana State University and A. & M. College. School of Social Welfare, Baton Rouge.

Some of the short courses: Workshops: Children in foster care (June 5-26); Children and public welfare (July 20-Aug. 7).

Nursery Training School of Boston. Boston 15, Mass.

For experienced nursery-school teachers: Child growth and guidance—a seminar; Teacher education through nursery school—a workshop; Nursery-school education for the physically handicapped child—a workshop. Also a try-out course for high-school students and others who are considering entering the field of early-childhood education. (June 29-Aug. 7.)

Smith College. School for Social Work. Northampton, Mass.

Graduate seminars for experienced social workers: Advanced casework; Supervisory method in social casework; Ego psychology; Psychodynamics of delinquency; Casework interpretation and writing; and Educational methods in teaching casework. (July 20-30.)

University of Chicago. School of Social Service Administration. Chicago 37, Ill.

Some of the workshops: Casework with children and adolescents (June 29-July 11); Work with parents of children in placement (July 20-25). Special lectures (daily): Adolescence as a phase in the development of the ego. (July 6-10.)

University of Minnesota. Minneapolis, Minn.

Under the sponsorship of a number of the University's colleges and schools, including the School of Social Work, the Family Life Division of General Studies, the Institute of Child Welfare, and others, the Family Life Workshop will emphasize the value of teamwork among professional workers in family-life education—teachers, marriage counselors, social workers, public-health workers, research personnel, and others in the family-life field. (July 6-24.)

University of Pennsylvania. Philadelphia 4, Pa.

The eleventh annual course in Family living and sex education is sponsored by the School of Education and the Institute for the Study of Venereal Diseases, University of Pennsylvania, in cooperation with the Public Health Service, Department of Health, Education, and Welfare; Pennsylvania State Department of Health; and the American Social Hygiene Association. It is intended for public-health workers, counselors, teachers, religious leaders, nurses, social workers, group leaders, and parents. (June 29-July 31.)



Aug. 16-22. World Federation for Mental Health. Sixth annual meeting. Vienna, Austria.

Aug. 25-28. American Dietetic Association. Thirty-sixth annual meeting. Los Angeles, Calif.

Aug. 30-Sept. 1. American Sociological Society. Forty-eighth annual meeting. Berkeley, Calif.

Aug. 31-Sept. 2. National Council on Family Relations. Annual conference. East Lansing, Mich.

Aug. 31-Sept. 3. American Hospital Association. Fifty-fifth annual convention. San Francisco, Calif.

Aug. 31-Sept. 3. American Legion. Thirty-fifth annual national convention. St. Louis, Mo.

Sept. 1-30. Sight Saving Month. Information from the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Sept. 3-8. United States Assembly of Youth. Sponsored by the Young Adult Council of the National Social Welfare Assembly. Ann Arbor, Mich.

Sept. 4-9. American Psychological Association. Sixty-first annual convention. Cleveland, Ohio.

Sept. 6-11. National Urban League. Annual conference. Philadelphia, Pa.

Sept. 10-12. American Political Science Association. Forty-ninth annual meeting. Washington, D. C.

Sept. 13-20. World Assembly of Youth Rural Youth Conference. Host: The Italian national committee for the World Assembly of Youth. (The Food and Agriculture Organization of the United Nations is assisting in the preparatory materials.) Address inquiries to: World Assembly of Youth, 6 rue Ampere, Paris 17, France.

Sept. 17. Citizenship Day. Information from the Citizenship Committee, National Education Association, 1201 Sixteenth Street NW., Washington 6, D. C.

Sept. 17-19. National Conference on Citizenship. Eighth annual meeting. Washington, D. C.

Sept. 25-27. American Society of Dentistry for Children. Twenty-sixth annual meeting. Cleveland, Ohio.

Sept. 27-Oct. 4. Christian Education Week. Sponsored by the National Council of the Churches of Christ, 79 East Adams Street, Chicago 3, Ill.

Sept. 28-Oct. 1. American Dental Association. Ninety-fourth annual session. Cleveland, Ohio.

Sept. 28-Oct. 2. National Recreation Association. Thirty-fifth National Recreation Congress. Philadelphia, Pa.

Regional conferences, American Public Welfare Association:

Sept. 9-11. West Coast Region. Los Angeles, Calif.

Sept. 24-26. Northeast Region. Washington, D. C.

Sept. 30-Oct. 2. Southeast Region. Jacksonville, Fla.

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